(1) 89-570

No. 89- .

In the

Supreme Court of the United States.

OCTOBER TERM, 1989.

THOMAS A. MORRIS, JR., M.D.,
PETITIONER,
v.
THE MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE,
RESPONDENT.

ON PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME JUDICIAL COURT OF MASSACHUSETTS.

PETITION FOR CERTIORARI.

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September 29, 1989

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Questions Presented.

I. Whether the prior invalid adjudication of misconduct on the part of petitioner physician by the respondent state board of registration upon the basis of insubstantial evidence forfeits the presumption of impartiality announced by *Withrow* v. *Larkin*, 421 U.S. 35 (1975), and as a requirement of the Due Process Clause of the Fourteenth Amendment compels the disqualification of the agency from a second prosecution of the case by reason of prejudgment demonstrated by

(a) the incumbent board members' specified and repeated rejection of the need for the remanded factfinding now ordered by the state supreme court;

(b) the incumbent board members' substitution of their own conclusive credibility findings for the contrary determination of the hearing magistrate in violation of the rule of *Universal Camera Corporation* v. *National Labor Relations Board*, 340 U.S. 474, 496-497 (1955), and of conforming state administrative law doctrine;

(c) the incumbent board members' avoidance of all countervailing evidence; and

(d) the incumbent board members' commitment to an adverse interpretation of unchanged circumstantial evidence.

II. Whether the board's protracted, defective, and repetitive submission of the physician to disciplinary proceedings violates his right to due process of law.

Parties to the Proceedings.

Petitioner, Plaintiff. The petitioner below was the plaintiff Thomas A. Morris, Jr., M.D.

Respondent, Defendant. The respondent below was the defendant Massachusetts Board of Registration in Medicine.

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PETITION FOR CERTIORARI.

Petitioner Thomas A. Morris, Jr., M.D., respectfully prays that the Court issue a Writ of Certiorari to review that portion of the judgment of the Supreme Judicial Court of Massachusetts entered on June 12, 1989, and concluded by denial of a petition for rehearing entered on July 28, 1989, which remands the case to the state board of registration in medicine for further prosecution.

Opinion Below.

The opinion and judgment of the Massachusetts Supreme Judicial Court are published at 405 Mass. 103, 539 N.E.2d 50 (1989). Their full text appears at pp. 1a-12a of the Petition Appendix (Pet. App.).

Jurisdiction.

The Massachusetts Supreme Judicial Court entered an order for final judgment on June 12, 1989 (Pet. App. at 13a). The petitioner filed a timely petition for rehearing (Pet. App. at 14a-22a). That court entered a denial of the petition on July 28, 1989 (*id.* at 25a).

The Court derives jurisdiction of the case from 28 U.S.C. § 1257(a) authorizing *certiorari* jurisdiction, *inter alia*, in controversies decided by the highest court of a state "where any title, right, privilege or immunity is specially set up or claimed under the Constitution . . .."

Constitutional Provisions Involved.

United States Constitution Amendment 14, § 1 (in pertinent part):

> nor shall any state deprive any person of life, liberty, or property, without due process law; . . . .

Statement of the Case.

I. The Underlying Facts.

The petitioner Thomas A. Morris, Jr., M.D., graduated from the University of Pennsylvania Medical School in 1941, and served in the medical corps of the Navy from 1942 to 1947. Upon discharge he undertook a residency in psychiatry at a Boston area hospital from 1948 to 1951. He became board certified in psychiatry in 1952, and continued his practice and training in Veterans Administration facilities.

From 1955 to 1972 he served on the staff of the Peter Bent Brigham Hospital and the Massachusetts Mental Health Center of the Harvard Medical School. At the Brigham Hospital he worked in the psychiatric gynecology clinic with concentration upon emotional factors affecting the reproductive function of women. Since 1972 he has engaged exclusively in private practice. From 1972 to 1977 he worked entirely at an office in Boston. In 1977 he moved his residence from Boston to the New Bedford area. Thereafter he divided his practice between offices in each city. During the portion of the week when he practiced in Boston, he resided with one of several daughters in the Boston area, most often with a daughter still residing in the adjacent city of Newton.

In May of 1977 a psychologist referred the patient K to him for therapy. K had been born in 1947; held a bachelor of arts degree and a master's degree in educational psychology; and, as of 1977, had finished most requirements for a doctoral degree in counseling psychology at a Boston area university, except for the completion of her clinical component and dissertation. She fulfilled her clinical requirements by performance of a pre-doctoral internship at a university mental health center during 1978 and thereafter proceeded to complete her dissertation and receive her Ph.D.

From May, 1977, onward, Morris saw K on a weekly basis at his Boston office. Her immediate problems resulted from a difficult and ongoing divorce proceeding and from the concomitant custody battle over her child, a daughter born in 1972.

In 1968, she had married a German national. After her husband had completed medical school in Germany, they moved in 1970 to the United States. In 1971 he undertook a surgical residency at a Boston area teaching hospital. In 1976 he failed his national board certification examinations. Thereafter the marriage deteriorated rapidly with considerable mutual hostility.

In early May of 1976 K elected to undergo a therapeutic abortion in Los Angeles, then returned to Boston and admitted herself to the in-patient psychiatric service at a university hospital and thereafter at a private clinic for treatment and testing of manic depressive syndrome for three weeks.

Approximately one year later, in late April of 1977, she admitted herself as a psychiatric in-patient for a period of three weeks, again with a diagnosis of manic depressive illness. Upon her release in mid-May, 1977, she began her physical separation from her husband and her therapy with Dr. Morris. Subsequent marital counseling proved unsuccessful.

After his first interview of K in May of 1977, Morris examined her entire prior hospitalization records and undertook weekly one-hour therapy sessions. He diagnosed K's condition as a cyclothalmic illness, a milder form of manic depressive disorder, characterized by mood swings, uneven appetite and sleeping, difficulty in the performance of work and daily organization, and the loss of usual satisfactions from regular activity. As of the end of January, 1980, Dr. Morris judged her problem to have grown from a cyclothalmic to a manic depressive disorder. Custody of the daughter alternated between K and her husband during that period.

In August of 1979 the decree of divorce became final. The probate court awarded custody of the child to her father. In the final days of August or opening days of September, he returned to Germany and took the daughter with him. K learned of the abduction during the Labor Day weekend. During the remainder of September and October she made efforts to learn of the child's whereabouts and to prepare legal and financial measures for her recovery. During these eight weeks she maintained her weekly appointments with Dr. Morris. Her last session in that series of nine visits occurred on October 31.

On November 1 she flew from Boston to Frankfurt and on to Cologne in order to undertake a custody proceeding in the German courts with the assistance of American and German counsel. K remained in Germany, or Europe, through November, December, and January. The custody effort concluded with hearings in the German court in January and proved unsuccessful. During this span, in late December or early January, K became pregnant by an English friend.

She returned to Boston on January 29, 1980, and kept an appointment with Dr. Morris on January 30. She was experiencing considerable physical pain (cramping, weight loss, dizziness) and was admitted to a university hospital for the first 10 days of February. Physicians there diagnosed her early pregnancy. Dr. Morris visited her for two therapy sessions at the hospital.

Upon her release she made plans to return to Germany for an appellate custody hearing in March. The appeal was unsuccessful. She returned again to Boston in late May or early June of 1980. She made three further office visits to Dr. Morris in June, and two in July. In July or August, for lack of funds, she moved to her parents' residence in the western Massachusetts area and terminated her treatment with Dr. Morris. The treatment ended on good terms. Because the therapy had not reached a resolution, K resumed it with a psychiatrist in western Massachusetts.

Three years later, on October 17, 1983, K lodged her allegations with the Board. As elaborated at trial, those allegations were that during all the therapy sessions of September and October, 1979, Dr. Morris had initiated, and that she had joined in, sexual activity in the form of fondling, touching, attempted intercourse, and street language. Doctor Morris categorically denied all such conduct.

II. Administrative and Judicial Proceedings (Including Assertion of Federal Question).

Eighteen months afterward, in April of 1985, the respondent Board of Registration in Medicine (the board) commenced the present action by issuance of an order to show cause against the doctor (Pet. App. at 26a-27a). The Order charged that during the period of September to November, 1979, Dr. Morris as a practicing psychiatrist had initiated sexual relations with the patient at least six times during scheduled therapy sessions at his office; and that such activity constituted gross misconduct in the practice of medicine in violation of Massachusetts statutory and regulatory provisions and exposed him to the sanctions of licensure revocation, suspension, censure, or reprimand (*id.*). The board simultaneously referred the case to the Massachusetts Division of Administrative Law Appeals ("DALA," a statutorily independent body of administrative magistrates) for the conduct of an adjudicatory hearing and the rendition of factual findings and a recommended decision including proposed conclusions of law (*id.* at 28a).

An administrative magistrate of DALA conducted five days of adjudicatory hearings on May 28, June 17, July 1, July 14, and July 21, 1986. On September 18, 1986, the magistrate rendered a Recommended Decision in favor of the respondent

physician. She found the case to reduce a conflict of credibility between the patient and the physician; upon testimony and demeanor found the doctor to be a "compelling and credible witness" of greater reliability than the complainant; and concluded that the Board had not carried its requisite burden of proof to establish the charged misconduct by a preponderance of the evidence (Pet. App. at 34a-38a).

The Board then maintained the case under advisement for 16 months. It did not conduct any further hearings. On February 3, 1988, it issued a final decision and order of 65 pages, rejecting the recommended decision, finding the physician to have committed the charged misconduct, and ordering the immediate revocation of his Massachusetts licensure (Pet. App. at 39a-93a).

In accordance with the governing statute, the doctor appealed the revocation to the single justice of the Supreme Judicial Court (Pet. App. at 94a-103a). The board filed the entire administrative record with the justice and opposed all relief. The justice reviewed the administrative record and entered a memorandum and order concluding that the board "did not have substantial evidence that the instances of sexual misconduct complained of occurred," and vacated the order of license revocation (Pet. App. at 104a-106a). The board then appealed to the full Supreme Judicial Court.

The full court affirmed the decision of the single justice upon the grounds that the finding of sexual misconduct was unsupported by substantial evidence; that it had failed to accord the magistrate's first-hand credibility finding the particular deference to which it was entitled; that the board had misinterpreted circumstantial evidence; and that it had improperly substituted an unsubstantiated expertise for the detection of sexual misconduct for nonexistent evidence (405 Mass. at 103-113; Pet. App. at 7a-11a).

The court, however, remanded the case to the board for further proceedings consistent with its opinion (405 Mass. at 114; Pet. App. at 12a). The doctor petitioned the court for rehearing upon its order of remand, and argued that the board had irrevocably prejudged the case against him and would now subject him to further protracted and repetitive prosecution in violation of his entitlement to procedural due process and in excess of the presumption of impartiality authorized by *Withrow* v. *Larkin*, 421 U.S. 35 (1975) (Pet. App. at 14a-23a). The court denied rehearing of the remanded issue (Pet. App. at 25a).

The board has subsequently scheduled seven days of hearings during October, November and December, 1989, for complete retrial of the charges before one of its own members as a specially assigned hearing officer. That member has previously voted, as part of a 6-0 unanimity, to overrule the credibility finding and recommended decision of the magistrate, to enter substituted detailed findings and reasoning subsequently reversed by the state Supreme Court, and to revoke the doctor's licensure (Pet. App. at 24a; vote of Dr. Dinesh Patel). It has denied any voluntary stay of those proceedings during the consideration of the present Petition for Certiorari. Its continuing membership consists of five of the six members who overruled the magistrate's credibility finding and entered an invalid finding and revocation sanction against him (Pet. App. at 24a).[1]

[1] The Board is comprised of seven statutory members. In its consideration and decision of the case, one abstained (Dr. Deterling). He remains a member. We presume his continued abstention. Of the six voters, two have left the board. One of those has been replaced. The other seat remains unfilled. Thus, four of the six members who would vote upon the proposed second prosecution have previously voted for adverse findings and revocation.

Argument.

For the following reasons the Court should grant the writ.

I. The Board's Original Adjudication Demonstrates Prejudgment Forfeiting the Presumption of Impartiality of *Withrow* v. *Larkin*, 421 U.S. 35 (1975), and Requiring Disqualification of the Agency as a Matter of Due Process.

The original adjudication by the Board carries a series of categorical errors betraying an identifiable prejudgment of the case. That prejudgment negates the presumption of neutrality accorded state administrative adjudicators by *Withrow* v. *Larkin*, 421 U.S. 35 (1975)[2] and, as a requirement of due process of law, deprives the board of any further authority to judge the charges. Moreover, the board's deficiencies do not have the character of circumstantial mistakes, or innocent mishaps amid subtle doctrine. Rather, they embody consistent and generic violations of administrative law principles. Viewed in either isolation or combination, these errors comprise categorical determinants of the boundary between presumed impartiality, on the one hand, and unconstitutional prejudgment, on the other.

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[2] The formulation of *Withrow*, 421 U.S. at 55 has been that, "[w]ithout a showing to the contrary, state administrators 'are assumed to be men of conscience and intellectual discipline, capable of judging a particular controversy fairly on the basis of its own circumstances,' " quoting from *United States* v. *Morgan*, 313 U.S. 409, 421 (1941).

A. *The Board Members Repeatedly Rejected the Value of Any Remand for Additional Factfinding and Insisted Upon Legally Insubstantial Evidence as "Overwhelming" Evidence of Their Preferred Finding. They Have Already Closed Their Minds Against the Exercise Commanded By the Reviewing Court.*

The original decision of the board (65 pages emerging after 16 months under advisement) was lengthy, detailed, and emphatic (Pet. App. at 39a-93a). At a number of points it characterized the circumstantial evidence, dispensed with the need for credibility evidence, and disavowed the utility of a remand (emphasis supplied):

> — (Pet. App. 40a). In her Recommended Decision which we reject on the basis of the *overwhelming evidence in the record*, the Administrative Magistrate found that the Board did not prove sexual misconduct by the Respondent in the context of his psychiatric relationship with the patient.
>
> — (Pet. App. 58a-59a). In neither its Findings of Fact nor its Conclusions and Recommended Decision does the Recommended Decision analyze or weigh *overwhelming and often undisputed evidence* . . ..
>
> — (Pet. App. 59a). If the Record did not contain, as it does, the *overwhelming evidence* of sexual misconduct, we would *remand* this case for further proceedings and findings.
>
> — (Pet. App. 69a). Since . . . the Record contains *overwhelming evidence* to show sexual misconduct, *we need not remand* this case to the Magistrate for admission of the excluded evidence.

— (Pet. App. 86a). Given the *overwhelming evidence* of sexual misconduct, this *case can be decided without remanding* the matter to the Magistrate.

In short, the majority of incumbent board members found legally insubstantial evidence to be so "overwhelming" that they could spurn both the hearing officer's first-hand credibility finding and the remand process itself. They made that determination upon solely circumstantial evidence still in the record now to be remanded. The effect of the Supreme Judicial Court's remand order is to ask the same board members to purge their minds of unchanged circumstantial evidence which they have previously characterized as so conclusive or "overwhelming" as to eliminate the role of credibility between the complainant and the accused.[3]

As the single justice observed upon his review of the record, the board could have remanded the case for further factfinding by the magistrate or could have conducted its own supplemental hearing, but did neither (Pet. App. at 105a). Instead of following that salutary course as an open-minded adjudicator, it relegated to immateriality the factfinder's credibility determination and contorted the circumstantial evidence. As the single justice observed, this case reduced to a classic dual of credibility (Pet. App. at 105a). The board's portrayal of it as a skillful examination of circumstantial evidence is singularly implausible and further indicative of its prejudgment.

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[3] The court criticized, as well, the board's untenable interpretation of certain elements of circumstantial evidence, including its inaccurate characterization of the patient's appointment times; its misplaced reliance upon equivocal statements from the complainant's successor psychiatrist; and its distortion of the complainant's supposedly romantic reference to herself in a letter to the doctor (405 Mass. at 111-112; Pet. App. at 10a-11a).

B. *The Board Attempted to Substitute Its Own Credibility Findings for the Contrary Findings of the Magistrate, In Violation of the Rule of* Universal Camera Corporation v. National Labor Relations Board, 340 U.S. 474, 496-497 (1955); *and of Conforming State Administrative Law Doctrine.*

In the course of its decision the board excused itself from multiple administrative law doctrines whose normal application would favor the respondent physician. In particular it knew well[4] and circumvented the rule of *Universal Camera Corporation* v. *National Labor Relations Board*, 340 U.S. 474, 496-497 (1955), and the conforming state law rule of *Vinal* v. *Contributory Retirement Appeal Board*, 13 Mass. App. Ct. 85, 94-95 & n.6 (1982), requiring an agency to give "substantial deference" to the credibility findings of a hearing officer. The Supreme Judicial Court found the board's substitution of its own credibility determination *in absentia* to be error and to deprive the board's findings of their required respect (405 Mass. at 110-114; Pet. App. at 8a-12a). The court also criticized the board's effort to shore up its credibility determination by invocation of an unexplained special expertise enabling it to identify the "red flags indicative of sexual abuse." The court reaffirmed its rejection of the board's attempt to substitute putative expertise for specific evidence, a tactic which it had denied to the board previously [405 Mass. at 113; Pet. App. at 11a, citing *Arthurs* v. *Board of Registration in Medicine*, 383 Mass. 299, 310 (1981)]. As the board's discussion of them in the course of decision makes plain, it was well aware of these doctrines and precedents but attempted instead to circumvent them (Pet. App. at 83a-86a). The agency's evasion of the credibility principle is a further determinant of partiality.

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[4] Petition App. at 83a.

C. *The Board Avoided Consideration of All Countervailing Evidence.*

Throughout its lengthy decision the board avoided any consideration (let alone disposition) of countervailing evidence (Pet. App. at 39a-93a). An honest adjudication requires the assessment of evidence tending to derogate from the ultimate finding. *Universal Camera* v. *National Labor Relations Board*, 340 U.S. 474, 488 (1955). The rule is well settled and well known in the board's jurisdiction. *New Boston Garden Corporation* v. *Board of Assessors of Boston*, 383 Mass. 456, 466 (1981) (authorities collected).

The purpose of that standard is "to limit the opportunity for transmuting a preconception into judgment by picking and choosing what will support that preconception and willfully ignoring whatever weighs against it." 383 Mass. at 474 n.11, quoting from L.L. Jaffe, Judicial Control of Administrative Action, 607 (1965).[5]

This tactic was still another categorical determinant of prejudgment.

D. *The Board Members have Committed Themselves to an Interpretation of Unchanged Circumstantial Evidence.*

In lieu of first-hand observation and credibility determination, the board members found "overwhelming" certain cir-

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[5] A decision of the Court of Appeals for the Seventh Circuit aptly describes the same *modus operandi* of administrative prejudgment, *International Union, United Auto Workers* v. *National Labor Relations Board*, 802 F.2d 969, 975 (1986):

> The [agency] seems to have confined its attention to evidence that supported its conclusion and to have ignored any contrary evidence — an ostrich's approach which administrative agencies are not authorized to follow.

cumstantial evidence, most of which remains unchanged in the record on remand. These circumstantial elements consist of evidence (1) that in September, 1979, the complainant informed a friend and priest that she was engaging in sexual intercourse with a therapist; (2) that a subsequent therapist viewed her behavior or "affect" as consistent with sexual abuse; (3) that Dr. Morris tolerated a substantial arrearage in her payments; (4) that on one occasion he dined with her after an appointment; (5) that on another he went to her residence for a session; (6) that the scheduling of appointments in September and October reflected afternoon and evening hours when other patients and staff were less likely to be present; (7) that the patient had information about the doctor's personal circumstances of divided residence between the Boston and New Bedford areas and about his son's enrollment at medical school; and (8) that she had sent him a letter from Germany in which she referred to herself as "this sweet patient" (Pet. App. at 59a; 84a-85a; and 89a-90a).

The Supreme Judicial Court has instructed the board that its interpretations of the testimony of the successor therapist, of the scheduled appointment times, and of the patient's letter reference are unsupported (405 Mass. at 111-112; Pet. App. at 9a-10a); but that its inferences from the other evidence may be permissible (405 Mass. at 112; Pet. App. at 10a).

The board's commitment to the latter evidentiary points as the major composition of its "overwhelming" circumstantial evidence is not capable of intellectual erasure at this point. If the previous corpus of evidence was "overwhelming," the remainder will turn out to be at least "substantial" for its purposes. By itself, that continuing interpretation of unchanged circumstantial evidence preordains the result of any further adjudication.

In doctrinal terms, the board's emphatic, pervasive, and detailed commitment upon the adjudicative facts of this case

violates the doctor's right to a fair proceeding under the Due Process Clause of the Fourteenth Amendment of the United States Constitution. The most definitive element of an irremediable prejudgment is the specificity of the adjudicator's prior disposition. The appropriate remedy for such incurable prejudgment is the disqualification of the adjudicator. 2 K. Davis, Administrative Law Treatise §§ 12.01, 12.02 (1958); Administrative Law in the Seventies, § 12.01 (1976) and 1980 Supp., §§ 12.01 and 12.02; 3 Administrative Law Treatise § 19.4 (1980); 4 Mezines, Stein & Gruff, Administrative Law, § 36.02[1] (1977 and 1986 Supp.); C.H. Koch, Jr., 1 Administrative Law & Practice, § 6.7 at 44 (1985). *Staton* v. *Mayes*, 552 F.2d 908, 914 (10th Cir.), *cert. denied* 434 U.S. 907 (1977); *Cinderella Career and Finishing Schools, Inc.* v. *FTC*, 336 F.2d 754, 760 (D.C. Cir. 1964) vacated and remanded on other grounds, 381 U.S. 739 (1965); and *Amos Treat & Co.* v. *SEC*, 306 F.2d 260, 264 (D.C. Cir. 1962). In this case the administrative agency long ago passed beyond the point-of-no-return to open-mindedness as to both its ultimate decision and the detailed findings and reasoning for that decision.

II. The Board's Protracted, Defective, and Repetitive Submission of the Physician to Disciplinary Proceedings Violates His Right to Due Process of Law.

The remand of this disciplinary adjudication to the board of registration over the objection of the doctor violates due process not only by reason of that agency's prejudgment of the adjudicative facts, but independently by reason of the infliction upon him of additional protracted and repetitive prosecutorial process.

As a result of the remand, the board has informed the doctor and his counsel that it has scheduled seven hearings days for a *de novo* trial of the entire case during the months of October, November and December, 1989.[6] Further, the board has refused to stay that process voluntarily for the period of the pendency and decision of the present Petition for Certiorari, but will require a stay order from the Supreme Judicial Court or this Court. It has assigned one of its members as the hearing officer. That individual has previously voted to revoke the doctor's license upon the basis of insubstantial evidence. The Supreme Judicial Court extended to the board the choice "to remand the matter to the administrative magistrate [who conducted the original five-day hearing] for further findings or for an explanation of her decision, or both;" or to order a new hearing. 405 Mass. at 113-114; Pet. App. at 11a-12a. The board has selected the option foreclosing further participation by the independent magistrate and imposing another full proceeding upon the physician.

As this Court has recognized, professional licensure revocation adjudications are not ordinary civil proceedings. "These are adversary proceeding of a quasi-criminal nature." *In Re Ruffalo*, 390 U.S. 544, 550-551 (1968). Their purpose is to protect the public and to punish the professional licensee.[7] Their character requires, therefore, scrupulous observance of the registrant's procedural due process rights.

The impending reprosecution of Dr. Morris by the agency which has already wrongly adjudicated him, whose legal errors and delays have extended the process by three years, and whose discredited decision will have more than doubled the time, effort, and cost of the entire proceeding, constitutes an independent violation of due process.

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[6] Board's letter of notice of September 6, 1989.

[7] "Disbarment, designed to protect the public, is a punishment or penalty imposed on the lawyer (cases collected)." 390 U.S. at 550.

The events in question took place now 10 years ago. Doctor Morris has aged from 63 to 73. His career of 48 years of practice is free of any other complaint. Eighteen months after the receipt of the patient's allegations, the board commenced these proceedings in April of 1985; took 16 months to review the magistrate's decision, and caused an additional 16-month span of judicial review in two proceedings in the state Supreme Court. Its contemplated remand trial extends over a three-month period and its subsequent indeterminate time for final decision will now add to that cumulative duration. The doctor will be entitled to further appropriate judicial review, a high probability in light of the history of this matter.

The continuing pendency of the disciplinary prosecution subjects the physician to ongoing tribulation, delay, expense, loss of livelihood, personal and professional disrepute, and personal and family demoralization. The process itself is punitive and destructive of those itemized due process property and liberty interests of the individual confronting it. The board's legal errors have now consumed three years since the delivery of the magistrate's decision and have punished the physician throughout the span. It is not entitled to pursue the effort any further.

In these circumstances of a repetitive quasi-criminal proceeding, the analogous principle of the Double Jeopardy Clause of the Fifth Amendment* applies forcefully. The Court has summed up its objectives in terms especially applicable to the present case, *Green* v. *United States*, 355 U.S. 184, 187-188 (1957):

> The underlying idea . . . is that the State with all its resources and power should not be allowed to make repeated attempts to convict an individual for an

*"[N]or shall any person be subject for the same offense to be twice put in jeopardy of life or limb . . .."

> alleged offense, thereby subjecting him to embarrassment, expense and ordeal and compelling him to live in a continuing state of anxiety and insecurity, as well as enhancing the possibility that even though innocent he may be found guilty.

In instances as this, in which the prosecuting agency has caused inordinate delay, had full and fair opportunity to establish its allegations, completed an adjudication and judicial review, and committed substantial legal error, it should not enjoy an entitlement to reprosecution but should be limited by the due process right of the defendant. In a case of the present category, due process should at this point mean final process.[9]

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[9] By unsuccessful petition for rehearing, we have presented the doctor's objection against remand and reprosecution to the Supreme Judicial Court as an issue of due process (Pet. App. at 21a-22a & n.4).

At the same time the Court's unanimous discussion and application of the Double Jeopardy Clause in *Halper* v. *United States*, 109 S.Ct. 1892 (May 15, 1989), indicates the unconstitutionality of the proposed reprosecution of the doctor by reason of the convergent puposes of that Clause. The Court concluded that a second prosecution for the same alleged wrongdoing by a nominally civil proceeding was practicably punitive rather than remedial. "Simply put, a civil as well as a criminal sanction constitutes punishment when the sanction as applied to the individual case serves the goal of punishment." *Id.* at 1901-1902. Accord, *Hicks* v. *Feiock*, 108 S.Ct. 1423, 1429-1431 (1988); *Kennedy* v. *Mendoza-Martinez*, 372 U.S. 144, 168 (1963).

Professional disciplinary proceedings are "quasi-criminal" and designed to penalize or punish the licensee. *In Re Ruffalo*, 390 U.S. 544, 550-551 (1968). In the present instance, the board of registration has charged Dr. Morris with the statutory offense of "gross misconduct in the practice of medicine" (Pet. App. at 26a). The associated disciplinary sanctions were "revocation, suspension or the censure and/or reprimand of the Respondent" (*id.* at 27a). It imposed revocation (*id.* at 92a-93a). Moreover, in the execution of its regular policy to publicize all disciplinary results, it published that sanction to approximately 28 organs of the media, other governmental agencies, health care providers, and medical service payers and insurers (*id.* at 107a). The latter process achieves a peculiarly public punishment or stigmatization of the respondent physician, as well as some considerable retribution and deterrence. *See Kennedy* v. *Mendoza-Martinez*, 372 U.S. at 168.

(*footnote continued*)

Conclusion.

For the foregoing reasons the Petitioner Thomas A. Morris, Jr., M.D., respectfully urges the Court to issue a Writ of Certiorari to the Massachusetts Supreme Judicial Court to determine whether that court's remand of the disciplinary charges to the board of registration for further prosecution violates the requirements of the Due Process Clause of the Fourteenth Amendment.

Respectfully submitted,

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September 29, 1989

In short, the dominant character of the present disciplinary process is punitive. Further, this case is one in which the government conducted a full proceeding; in which the physician prevailed in the findings of the trial officer or magistrate (*id.* at 31a-38a); in which the government improperly attempted to reverse those findings (*id.* at 82a-93a); and in which it now seeks a second prosecution after acquittal, a paradigm abuse prohibited by the Double Jeopardy Clause, *North Carolina* v. *Pearce*, 395 U.S. 711, 717 (1969). The Due Process Clause of the Fourteenth Amendment, which applies the doctrine of double jeopardy to the states, *Benton* v. *Maryland*, 395 U.S. 784 (1969), forbids any further prosecution of Dr. Morris.

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Appendix A.

THOMAS A. MORRIS, JR. *vs.* BOARD OF REGISTRATION IN MEDICINE.

Suffolk. March 8, 1989. — June 12, 1989.

Present: WILKINS, ABRAMS, NOLAN, & O'CONNOR, JJ.

Board of Registration in Medicine. Administrative Law, Agency, Proceedings before agency, Evidence, Decision, Findings. *Evidence*, Administrative proceeding, Relevancy and materiality. Credibility of witness. *Division of Administrative Law Appeals.*

An administrative magistrate who issued a recommended decision in a disciplinary proceeding before the Board of Registration in Medicine against a physician charged with engaging in sexual conduct with a patient, and who based her conclusion that no sexual conduct took place "in part on my finding that the testimony of the [physician] was more credible than [the patient's] testimony" should have made an explicit analysis of credibility and the evidence bearing on it. [107]

The record of a hearing before an administrative magistrate in a disciplinary proceeding against a physician charged with engaging in sexual conduct with a patient showed no intrusion into the patient's prior mental history that was so extensive or invasive as to have been likely to have prejudiced the patient in the eyes of the administrative magistrate. [107-108]

Although, in a disciplinary proceeding against a physician charged with engaging in sexual conduct with a patient, the administrative magistrate improperly admitted evidence of the patient's sexual history, which had no relevance to any important issue of fact, the admission of this evidence was not an abuse of discretion where, on the record, there was no indication that the magistrate's decision was influenced by the evidence or that the evidence made the patient ineffective as a witness. [108-109]

This court adopted the standard expressed by the Appeals Court in *Vinal* v. *Contributory Retirement Appeal Bd.*, 13 Mass. App. Ct. 85 (1982), that, when the subsidary findings of an administrative magistrate rest on a resolution of credibility questions, the magistrate's findings should be entitled to substantial deference. [110-111]

Where, in an action for judicial review of a decision of the Board of Registration in Medicine, this court concluded that the board, by disregarding the findings of an administrative magistrate, had failed to give substantial deference to the magistrate's findings on matters of credibility, it was appropriate in the circumstances for the board either to remand the case to the magistrate, for further findings, an explanation of her decision, or both, or, instead, to order a new hearing. [109-110, 111-114]

CIVIL ACTION commenced in the Supreme Judicial Court for the county of Suffolk on March 7, 1988.

The case was heard by *Lynch*, J.

Despena Fillios Billings, Assistant Attorney General, for the defendant.

Mitchell J. Sikora, Jr., for the plaintiff.

Thomas R. Kiley & Dean P. Nicastro, for Massachusetts Medical Society, amicus curiae, submitted a brief.

Gail E. Horowitz & Alice E. Zaft, for Women's Bar Association, amicus curiae, submitted a brief.

WILKINS, J. The plaintiff physician, a psychiatrist, was charged before the defendant board with engaging in sexual conduct with a patient, which, if it occurred, would be a violation of G. L. c. 112, § 5 (*c*) (1986 ed.) ("gross misconduct in the practice of medicine"). The board referred the case to the Division of Administrative Law Appeals to hold a hearing and then to issue recommended findings of fact and a recommended decision. An administrative magistrate issued a recommended decision in which she concluded that the baord had not proved the alleged misconduct. The administrative magistrate believed the physician and not his former patient. More than one year later, the board issued its final decision, revoking the physician's registration to practice medicine on the ground that he had engaged in sexual activity with his patient.

The principal issue of contention in the physician's appeal from the board's decision is whether the board, in the circumstances, was warranted in rejecting the administrative magistrate's determination of the credibility of the physician and the patient and in deciding that issue differently, based on its reading of the record. A single justice of this court concluded that the board was not so warranted, and he vacated the board's decision. The single justice concluded that the board did not have substantial evidence on the record to support its conclusion that the instances of alleged sexual misconduct occurred. The board has appealed. We affirm the judgment vacating the board's decision and order the matter remanded to the board for further proceedings consistent with this opinion.

Dr. Morris, who had practiced medicine since 1942 without a prior complaint, had an office on Marlborough Street in Boston. The patient began seeing him for psychotherapy on a weekly basis in May, 1977, because of anxiety arising out of her deteriorating marriage and a dispute over the custody of her daughter. The physician participated in support of the patient's attempt to obtain custody of her daughter. In August, 1979, the patient's divorce became final, and the former husband obtained custody of their child. He remarried immediately and, contrary to court order, took the child out of the country.

The alleged sexual conduct between the patient and the physician occurred in the physician's office in the months of September and October, 1979. The board makes no claim that the patient did not consent. The physician in turn concedes that it would be improper and not consistent with accepted medical practice for a psychiatrist to engage even in consensual sexual activity with a patient. At that time the patient was still seeking to regain custody of her child. The board concluded that the physician first engaged in sexual activity with the patient in early September, 1979. He attempted, unsuccessfully, to have intercourse with her. The patient testified that she felt that, if she did not comply, he would abandon her. The board found that during each of the successive sessions with the patient until she left the country in November, 1979, to attempt to regain custody of her child, the patient and the physician engaged in sexual activity, but that sexual intercourse was never consummated.

The board noted that the administrative magistrate's recommended decision provided no discussion of the evidence in explanation of her decision that no sexual activity occurred during any of the therapy sessions. The magistrate did say that her conclusion was "based in part on my finding that the testimony of the [physician] was more credible than [the patient's] testimony." She added that she had had ample opportunity to observe the demeanor of the witnesses, including their appearance and general bearing. She described the physician as a "compelling and credible witness," and found unconvincing

the patient's testimony concerning repeated sexual encounters with the physician.[1]

In a thorough decision, explaining at length why it believed the patient, the board concluded that the evidence of sexual misconduct was overwhelming. It noted the advantage a psychiatrist has in relation to a patient; the particular vulnerability of the patient at the time the sexual activity allegedly occurred; the scheduling of the patient's appointments late in the afternoon; her statement on September 22, 1979, to an acquaintance (discussed later) which the board viewed as a fresh complaint concerning the physician's activity; the testimony of the patient's subsequent phychiatrist; the physician's disclosure of personal information about himself and his family to the patient; the conducting of therapy sessions away from his office; dining alone with the patient; allowing her bill to accumulate to an average of $4,000 and helping her once financially; and the contents of a letter the patient wrote to the physician from abroad in November, 1979. The board concluded that the physician engaged in inappropriate sexual and other activity with the patient that amounted to a violation of good and accepted psychiatric care, and gross misconduct in the practice of medicine in violation of G. L. c. 112, § 5 (*c*).

The board would have been warranted in remanding the case to the adminisitrative magistrate for supplemental findings and for more detailed explanations of her reasoning. It would also have been warranted in ordering a new hearing before a different magistrate. We reject, however, the board's decision that, in the circumstances, the board itself could properly make the finding that the physician had engaged in sexual activity with the patient. For reasons we shall explain, the board owed

[1] The board noted the magistrate's failure to comment on what it regarded as critical evidence. The board listed as critical and as ignored the following: "[T]he corroborating testimony of [an acquaintance] showing a 'fresh complaint,' the corroborating testimony from the Patient's own psychiatrist, the undisputed facts that the [physician] made at least one (and we conclude more than one) house call(s), that he provided her with a therapy session' in his car, that he dined alone with the Patient, that they had personal financial dealings, and the potential adverse effect of the unwarranted questioning on the Patient's demeanor."

greated deference than it paid to the credibility findings made by the magistrate who heard the witnesses.

We agree with the board that the magistrate's recommended decision was sparse in explanation of her determination of the central factual issue. She said that she based finding that no sexual conduct took place "*in part* on my finding that the testimony of the [physician] was more credible than [the patient's] testimony" (emphasis supplied), but she did not explain what else she relied on in making that finding. She did not discuss certain evidence and possible inferences from the evidence that tended to support the opposite finding. In this case, the magistrate should have made an explicit analysis of credibility and the evidence bearing on it. Although we are not as certain as the board that the magistrate was preoccupied with the absence of eyewitnesses, the board would have been justified in seeking a further explanation from the magistrate of the significance in her view of the absence of eyewitnesses.

The board also concluded that the administrative magistrate's decision may have been affected by certain evidence she improperly admitted. The board stated that the magistrate should have more closely controlled the admission of evidence of the patient's mental history. The probative value of this extensive evidence, the board said, "was completely overshadowed by the invasive nature and possible prejudicial effect." The board thought the unwarranted intrusion might have affected the patient's demeanor and thus improperly influenced the magistrate's findings on credibility. The magistrate did not expressly rely on this evidence. The board did not rule that the evidence was irrelevant. The rules of evidence generally do not apply in administrative hearings governed by G. L. c. 30A. G. L. c. 30A, § 11 (2) (1986 ed.).[2] Our reading of the record shows no intrusion that was so extensive or invasive on the subject

[2] Rules concerning evidentiary privilege apply in proceedings governed by G. L. c. 30A, § 11 (2). The applicability of the psychotherapist-patient privilege (G. L. c. 233, § 20B [1986 ed.]) was not raised at the hearing as to communications between the patient and the physician. The exception in paragraph (*f*) concerning disclosure of communications in a license revocation proceeding would have justified admission of relevant communications.

of prior mental history as to have been likely to have prejudiced the patient in the eyes of an experienced administrative magistrate. An administrative magistrate must have considerable discretion, particularly early in a hearing, to admit evidence that is arguably relevant, particularly where, as here, counsel makes no objection that the evidence is prejudicial.

We share the board's concern that the magistrate, over repeated objection, permitted "the [physician's] counsel unfettered latitude to inquire into minute details of the Patient's sexual history." The magistrate doubted its relevance when she admitted that evidence. The board's decision says that the evidence was "of questionable relevance." We can see now that it had no relevance, and the physician does not argue here that it did. The public policy expressed in the rape-shield statute[3] and in our common law decisions[4] requires that an administrative magistrate reject that kind of evidence in a proceeding like this, unless the proponent of the evidence demonstrates that evidence of a patient's prior sexual conduct is more than marginally relevant to an important issue of fact.

We do not agree with the board, however, that the magistrate's decision to admit the evidence was an abuse of discretion or that she "improperly shifted the focus from the [physician's] alleged misconduct to the issue of a consensual relationship between the [parties]." At the time the evidence was admitted, counsel who then represented the physician made a representation. He argued that he would show that the patient mixed fact and sexual fantasy and that such a showing would be "extremely important in evaluating the veracity of the witnes-

[3] General Laws c. 233, § 21B (1986 ed.), barring admission of evidence of the reputation of a victim's sexual conduct in certain criminal proceedings with limited exceptions.

[4] Special instances of a victim's prior sexual conduct with others has not been admissible under the common law in rape cases. See *Commonwealth* v. *Joyce*, 382 Mass. 222, 227 (1981). Where, as here, consent to sexual conduct is not in issue, the case against admission of specific or general prior sexual behavior is even stronger.

ses." That promise seems never to have been fulfilled as to the patient's statements about her prior sexual conduct.[5]

Admission of this evidence did not shift the focus of the inquiry to the matter of consent. Everyone agreed that consensual conduct was not the issue. The magistrate was avowedly skeptical of the relevance of the evidence. On the record, we see no indication that the magistrate's decision was influenced by this evidence or, as the board concluded, that this line of inquiry created "considerable reason to question the Magistrate's rejection of the Patient's testimony on the basis of 'demeanor,' 'appearance,' and 'general bearing,'" As best one can tell from the reading of a cold transcript, this evidence did not make this patient ineffective as a witness, a condition that could well develop with a different witness in similar circumstances. (See *Globe Newspaper Co.* v. *Superior Court*, 379 Mass. 846, 859, vacated on other grounds, 449 U.S. 894 [1980]. *S.C.* 383 Mass. 838 [1981], rev'd on other grounds, 457 U.S. 56 [1982]).

Although we agree in certain respects with the board's concerns about the magistrate's recommended decision, we do not accept the board's determination that it was entitled to disregard the magistrate's finding on credibility and make its own determination on the central factual issue in the proceeding. In the absence of a statute directing otherwise, we have required that one who has heard the witnesses in an agency proceeding make an assessment of credibility when there is a material conflict in the testimony. See *Salem* v. *Massachusetts Comm'n Against Discrimination*, 404 Mass. 170, 175 (1989) (commissioner who heard witnesses died before making decision; decision on printed record by another commissioner not permissible where testimony conflicted on material issues); *Dowd* v. *Director of the Div. of Employment Sec.*, 390 Mass. 767, 771 (1984) (review examiner who heard evidence should choose between conflicting versions of material events). Cf. *Amherst-Pelham Regional School Comm.* v. *Department of Educ.*, 376 Mass. 480, 498 (1978) (where credibility of witnesses is not involved

[5] In this circumstance, the board prosecutor's motion to strike this evidence admitted de bene should have been allowed or, at least, the magistrate's decision should have expressly disavowed reliance on that evidence.

hearing officer who did not hear witnesses may issue decision); *Perkins* v. *School Comm. of Quincy* 315 Mass. 47, 52-53 (1943) (where statute required attendance at hearing by school committee members who were to vote, reading transcript was not adequate substitute for attendance); G. L. c. 30A, § 11 (7) (1986 ed.) (by implication permitting majority of officials of agency who are to render final decision either to hear or to read evidence), discussed in *Board of Appeals of Maynard* v. *Housing Appeals Comm. in the Dep't of Community Affairs*, 370 Mass. 64, 66 (1976).

We have never held, however, nor does the physician argue here, that the administrative agency responsible for making the final decision may not revise or reject the findings of a hearing officer on conflicting evidence.[6] The physician makes no claim that any general constitutional principle, such as the denial of due process of law, always bar an agency from reversing the findings of fact of a hearing officer made on conflicting evidence.[7] He does argue, however, that in these circumstances the agency's decision denied him fairness in a due process sense.

Although this court had not addressed the degree of deference an administrative board must give to subsidiary findings of fact made by an administrative magistrate, the Appeals Court did so in a carefully reasoned opinion by Chief Justice Hale. *Vinal* v. *Contributory Retirement Appeal Bd.*, 13 Mass. App.

[6] By a letter appropriately presented after his brief was filed, the physician cites our recent opinion in *Salem* v. *Massachusetts Comm'n Against Discrimination*, *supra* at 174-175, but does not argue that it alters the law previously established.

[7] For many years under the workers' compensation act, a reviewing board that did not hear the witnesses had the right by statute (G. L. c. 152, § 10, prior to its amendment by St. 1985, c. 572, § 24) to reverse a single member's findings of fact. In answer to a challenge not based on any theory of unconstitutionality, we saw no basis for a restriction on the reviewing board "where a decision involves a disbelief of testimony and results in a conclusion of fact different from that of the single member who heard the witnesses even though the testimony which is disregarded is not in any way contradictory or improbable." *Fountaine's Case*, 246 Mass. 513, 517 (1923). Compare G. L. c. 152, § 11C (1986 ed.), which denies the reviewing board the right to "review determinations by the member who conducted the hearing regarding the credibility of witnesses who have given testimony," discussed in *Lettich's Case*, 403 Mass. 389, 394-395 (1988).

Ct. 85, 99-102 (1982). That court concluded that, when the subsidiary findings of a hearing officer rest on a "resolution of credibility questions (i.e., that a fact is true because a witness testified to it and that witness is believable), they should be entitled to substantial deference." *Id.* at 101. See *Universal Camera Corp.* v. *NLRB*, 340 U.S. 474, 496 (1951). The Appeals Court added that, if the board were to reject subsidiary findings of a hearing officer, it must comply with the requirement of G. L. c. 30A, § 11 (8) (1986 ed.), that its decision contain "a considered articulation of the reasons underlying that rejection." *Vinal, supra* at 101-102. We accept the substantial deference standard expressed in the *Vinal* opinion. By using that standard we preserve to the board the right to exercise its judgment and statutory responsibility (see A. Cella, Administrative Law and Practice §§ 347, 349 [1986]), while recognizing the right to a physician to have the proceeding decided on the question whether there was substantial evidence on the whole record supporting the board's decision. We turn, therefore, to a consideration of the board's decision to see whether, in articulating its reason for rejecting the magistrate's resolution of credibility questions, the board gave substantial deference to the magistrate's findings.

In certain respects, the board's reasoning is not persuasive. The board was plainly wrong in concluding that it was aided on the credibility issue by having the benefit of transcripts which were not available to the magistrate. The board's reliance on the assertion that the patient was scheduled in September and October, 1979, as the last patient in the day in order to avoid detection of the physician's misconduct by others, is not supported by the facts agreed to by the parties.[8] We substantially discount the patient's statements given to a successor psychiatrist made after the patient had commenced a civil action against the doctor based in part on her claim of the physician's

[8] The appointments in those months were held at the doctor's office at 11:10 A.M., 5:10 P.M., 3:30 P.M., 1:50 P.M., 6:30 P.M., 4:20 P.M., 7P.M., 6 P.M., and 3:30 P.M. We discern no pattern in support of the patient's claim, on which the board relied, that the appointments were held when other people would not be around.

improper sexual conduct toward her. Such self-serving statements do little to provide worthwhile corroboration. We see little support for the board's reliance on the language used in a letter the patient wrote the physician in November, 1979, referring to herself as "this sweet patient." In context, the words are not significant to this case.

There was, to be sure, evidence that tended to support the board's conclusion that the patient was telling the truth. The board noted that a psychiatrist learns a great deal about a patient's weaknesses, emotions, and thoughts and is in a position to take advantage of a patient. In this case, the alleged advances occurred, not coincidentally the board thought, at a time when the patient was particularly vulnerable because of the loss of custody of her child. There was evidence that the physician had disclosed details of his personal life to the patient and had, in the board's view, compromised the professional relationship in other ways by letting her bill mount up without any substantial payments and by giving her proceeds from a Blue Shield check; by taking the patient to dinner alone at the University Club, and by having sessions in inappropriate places, such as at her residence and in his automobile parked on a public street. Some corroboration of the patient might be found in the testimony of an acquaintance of the patient, a college professor, who testified to what he described as "bizarre conversation" he had had with the patient on September 22, 1979, during which the patient said that her psychiatrist, not named, had had intercourse with her. Before the magistrate, however, the patient testified that the physician was unable to have intercourse on any occasion.

If the board had heard the evidence and had issued a decision as carefully crafted and as well directed to the evidence in the record as the one it issued, we would have no difficulty in concluding that there was substantial evidence on the whole record to support the board's conclusions. Here, however, the board did not hear the evidence. It concluded, nevertheless, that what it viewed as overwhelming evidence of sexual misconduct made it unnecessary to obtain corrections and amplifications from the person who did hear and see the witnesses.

Moreover, in deciding that there was overwhelming evidence, the board relied on its understanding of the "dynamics" of a psychiatrist-patient relationship involving sexual exploitation. The board said that "through our work in the field and handling of disciplinary cases, we have gained an understanding of how to interpret and weigh the particular facts in an case of sexual abuse. It is through this insight and expertise in reviewing such cases that we can identify certain red flags indicative of sexual abuse. Without this appreciation, critical facts can be misinterpreted or worse yet, ignored."

The board exceeded its proper role in announcing, with no expert evidence in the record to support it, that its special expertise permits it to identify "red flags indicative of sexual abuse." If there is some method known to medical science for determining whether sexual misconduct has occurred in particular circumstances, that information should be disclosed on the administrative record, presumably in the form of an expert opinion. See G. L. c. 30A, § 11 (5) (1986 ed.). The board failed to give substantial deference to the findings of the magistrate on matters of credibility when it substituted a collective assessment that was based on the undisclosed significance of certain "red flags". *Arthurs* v. *Board of Registration in Medicine*, 383 Mass. 299, 310 (1981). If, as the board indicates, these "red flags" are something more than evidence tending to prove certain facts or tending to corroborate the testimony of certain witnesses (the kind of evidence triers of fact have traditionally relied on), they and their importance must be disclosed on the record so that a physician may challenge that evidence. *Id.* at 305.

Where the magistrate concluded that the physician was credible and where the record lacked evidence to support the significance of the "red flags" the board relied on, the board's decision was not supported by substantial evidence on the whole record. We do not conclude, however, that a judgment here or a board decision in favor of the physician is required. The board may wish to remand the matter to the administrative magistrate for further findings or for an explanation of her

decision, or both.[9] The board may choose instead to order a new hearing.

We affirm the judgment of the single justice vacating the decision of the board and remand the matter to the board for further proceedings consistent with this opinion.

So ordered.

[9] In circumstances not disclosed on the record, the physician's counsel obtained an affidavit from the administrative magistrate explaining her findings on credibility and rebutting the board's criticism of her recommended decision. The affidavit was filed at the same time the physician's complaint was filed. The board moved to strike the affidavit. The single justice took no action on the motion and does not appear to have relied on the affidavit in making his decision.

COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT FOR THE COMMONWEALTH,

AT BOSTON, June 12, 1989

IN THE CASE NO. SJC-S-4853

THOMAS A. MORRIS, JR.,

vs.

BOARD OF REGISTRATION IN MEDICINE

pending in the Supreme Judicial Court for the County of Suffolk No. 88-81

ORDERED, that the following entry be made in the docket; viz., —

We affirm the judgment of the single justice vacating the decision of the board and remand the matter to the board for further proceedings consistent with the opinion.

BY THE COURT,

/s/ _____, CLERK.

June 12, 1989

See opinion on file.

Appendix B.

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June 23, 1989

Honorable Herbert P. Wilkins
Justice of the Supreme Judicial Court
1412 Suffolk County Courthouse
Boston, MA 02108

Subject: Thomas A. Morris, Jr., M.D.
v.
Massachusetts Board of Registration in Medicine.

SJC No. 88-81
Decision and opinion released June 12, 1989.

Petition for Rehearing Pursuant to Mass. R.A.P. 27.

Dear Justice Wilkins:

In accordance with Mass. R.A.P. 27, I submit the following letter as a petition for rehearing in behalf of the plaintiff appellee Thomas A. Morris, Jr., M.D. I enclose also the requisite seven copies. The petition addresses solely the court's dispositive order to "remand the matter to the board for further proceedings consistent with this opinion." For a number of reasons I believe that the facts and law of the case preclude a remand. The reasons appear in the Appellee's Brief at pages 48-53 as Argument III. They did not receive discussion in the court's opinion. In our view the opinion of the court, affirming the single justice's reversal of the board's decision, strengthens the grounds against a remand. I itemize them as follows.

1. *The board's prejudgment and commitment to the invalidated result.* Six of the board's seven members voted to adopt the administrative decision of this case (members Bodner, Ego, Prout, Liang, Patel, and Milberg). One member abstained (Deterling). As Appendix A I attach a copy of the Board's published minutes of its meeting and pertinent voting of February 3, 1988. Since that vote, only member Milberg has left the board for a successor. We understand that Dr. Deterling abstained by reason of prior professional contact with Dr. Morris. Consequently, of the six members available to vote upon the case in a remanded proceeding, five voted "to adopt the recommended decision" which the single justice and the panel have subsequently reversed for lack of substantial evidence.

The decision (65 pages emerging after 16 months under advisement) adopted by the board members was lengthy, detailed, and emphatic (RA 64-128). At a number of points it characterized the circumstantial evidence, dispensed with the

need for credibility evidence, and disavowed the value of a remand (emphasis supplied).

> — RA 65. In her Recommended Decision which we reject on the basis of the *overwhelming evidence in the record*, the Administrative Magistrate found that the Board did not prove sexual misconduct by the Respondent in the context of his psychiatric relationship with the patient.
>
> — RA 87. In neither its Findings of Fact nor its Conclusions and Recommended Decision does the Recommended Decision analyze or weigh *overwhelming and often undisputed evidence* . . . .
>
> — RA 88. If the Record did not contain, as it does, the *overwhelming evidence* of sexual misconduct, we would *remand* this case for further proceedings and findings.
>
> — RA 100. Since . . . the Record contains *overwhelming evidence* to show sexual misconduct, *we need not remand* this case to the Magistrate for admission of the excluded evidence.
>
> — RA 120. Given the *overwhelming evidence* of sexual misconduct, this *case can be decided without remanding* the matter to the Magistrate.

In sum, the incumbent board members found legally insubstantial evidence to be so "overwhelming" that they could spurn both the hearing officer's first-hand credibility finding and the remand process itself. They made that determination upon solely circumstantial evidence still present in the record now to be remanded. The effect of the court's remand order is to ask the same board members to purge their minds of

certain items of circumstantial evidence which they have previously insisted upon as telling (court's slip opinion at 12 [405 Mass. 111-112]: board's inaccurate characterization of the patient's appointment times; its misplaced reliance upon statements from the complainant's successor psychiatrist; and its distortion of the complainant's reference to herself as "this sweet patient" in a letter to the doctor); to calibrate downward other unchanged elements of circumstantial evidence from the level of overwhelming to insubstantial probative value (slip opinion at 12-13 [405 Mass. 112]); to undertake neutrally and objectively the credibility determination which it has previously denigrated as legally immaterial to, or redundant of, its settled knowledge; and to renounce a self-imputed expertise for the detection of sexual misconduct among individuals (slip opinion at 14-15 [405 Mass. 113]). The emphatic tenor of the Board's original decision leaves little doubt that, even if it had in the first instance obeyed the court's present directive (subtraction of the invalid circumstantial evidence identified by the court and proper respect for the credibility finding of a trial officer) and even if it obeys it now, it has more than enough circumstantial material in the present record to satisfy itself of a preponderance of evidence for its preferred result.

In doctrinal terms, the board's emphatic, pervasive, and detailed commitment upon the adjudicative facts of this case violates the doctor's right to a fair proceeding under the state administrative procedure act, G.L. c. 30A, § 10; under the guarantee of judicial and adjudicatory impartiality by Article 20 of the Declaration of Rights of the Massachusetts Constitution; and under the Due Process Clause of the Fourteenth Amendment of the United States Constitution. The most definitive element of an irremediable prejudgment is the specificity of the adjudicator's prior disposition. The appropriate remedy for such incurable prejudgment is the disqualification of the adjudicator. 2 K. Davis, *Administrative Law Treatise*, §§ 12.01, 12.02 (1958); *Administrative Law In The Seventies*,

§ 12.01 (1976) and 1980 Supp., §§ 12.01 and 12.02; 3 *Administrative Law Treatise* § 19.4 (1980); 4 Mezines, Stein & Gruff, *Administrative Law*, § 36.02[1] (1977 and 1986 Supp.); C.H. Koch, Jr., 1 *Administrative Law & Practice*, § 6.7 at 44 (1984). *Staton* v. *Mayes*, 552 F.2d 908, 914 (10th Cir. 1977), *cert. denied* 434 U.S. 907; *Cinderella Career and Finishing Schools, Inc.* v. *FTC*, 336 F.2d 754, 760 (D.C. Cir. 1964) vacated and remanded on other grounds, 381 U.S. 739 (1965); and *Amos Treat & Co.* v. *SEC*, 306 F.2d 260, 264 (D.C. Cir. 1962). In this case the administrative agency long ago passed beyond the point-of-no-return to open-mindedness as to both its ultimate decision and the detailed findings and reasoning for that decision.

2. *The board's avoidance of all contrary evidence.* Throughout its lengthy decision the board avoided any consideration (let alone disposition) of countervailing evidence. This visibly partisan treatment substantiates its prejudgment of the case. An honest adjudication requires the assessment of evidence tending to derogate from the ultimate finding. *Universal Camera* v. *NLRB*, 340 U.S. 474, 488 (1955); *New Boston Garden Corporation* v. *Board of Assessors of Boston*, 383 Mass. 456, 466 (1981); *Griffin's Brandt Rock Package Store, Inc.* v. *ABCC*, 12 Mass. App. Ct. 768, 770 (1981); *Southern Worcester Regional Vocational School District* v. *Labor Relations Commission*, 12 Mass. App. Ct. 189, 197-198 (1981). In this instance that exercise required judicial review. As the court observed (slip opinion at 12 [405 Mass. 112]), the board attempted to bend elements of circumstantial information into the shape of favorable evidence; and attempted the implausible rationale that it had an advantage over the magistrate in the determination

of credibility by reason of its consultation of transcripts not contemporaneously available to her.[1]

3. *The board's self-conscious avoidance of pertinent legal doctrines*. In the course of its decision the board excused itself from multiple administrative law doctrines whose normal application would favor the respondent physician. It knew well and circumvented the rule of *Universal Camera Corporation* v. *NLRB*, 340 U.S. 474, 496-497 (1955), and *Vinal Contributory Retirement Appeal Board*, 13 Mass. App. Ct. 85, 94-95 & n.6 (1982) requiring "substantial deference" for the credibility findings of a hearing officer (RA 53-54). It ignored the rule of *Arthurs* v. *Board of Registration in Medicine*, 383 Mass. 299, 309-311 (1981), explicitly forbidding its substitution of hypothetical expertise for genuine evidence, and attempted the tactic again (RA 120-122). It attempted to substitute a treatise reference for the missing evidence and expertise in violation of the administrative notice requirement of G.L. c. 30A, § 11(5) (RA 123, 125-126). As discussed above, it ignored completely the evaluation of countervailing evidence contemplated by *Universal Camera*, 340 U.S. at 474 and *New*

[1] Indeed, the board carried the avoidance of countervailing evidence to new reaches. It offered speculative explanations for contrary information on the rare occasions when it did confront it. It characterized the complainant's threat to impute false paternity to another physician as "moment of disorganized and euphoric thinking" rather than as a detraction from her credibility (RA 106). Similarly it conjectured that her threat in July of 1980 to sue her various doctors for funds was more likely a reference to her former husband by then in Germany and beyond the jurisdiction of any feasible damages action (RA 113).

More ironically, on appeal, it conceded that a majority of its participating members supposedly enjoying the reflective advantage of transcript reading had, after all, not reviewed the trial record and had not issued a compensating tentative decision under G.L. c. 30A, § 11(7), because they had exempted themselves from that responsibility by a regulation promulgated 11 months after the submission of the magistrate's decision to the Board (board's Reply Brief at 2-5). This cynical shell game does little to inspire confidence in the agency's intellectual integrity and its trustworthiness in any subsequent consideration of the case.

Boston Garden Corporation, 383 Mass. at 466. It even avoided the responsibility that a majority of its voting members read the record of the underlying evidentiary hearing from which they purported to draw the circumstantial evidence "overwhelming[ly]" contradictory of the trial officer's five days of credibility observation (board's Reply Brief at 2-5).

The self-conscious quality of these evasive rationales is especially offensive to the value of fair and conscientious adjudication.[2] This case is not an instance in which a well-meaning agency has stumbled over a single and subtle doctrine. It is an episode in which a predisposed adjudicator has steered a devious course between multiple basic rules of impartial process and accurate factfinding so as to arrive at a preconceived destination.[3]

4. *The board's rejection of the remand process*. More than any other indicium, the board's refusal to remand a credibility case for further finding or explanation betrays its prejudgment. An agency proceeding with good faith objectivity would have, and should have, done so. See the observation of the single justice at RA 871. Its own repeated awareness of that neutral and proper alternative is telling. Once again it was aware of a legally correct rule and course of action. Once again it rejected it. After an additional 16 months of legal effort and delay, this court had to reverse the error and order the agency to

[2] The court's characterization of the board's decision and of its deficiencies seems unduly charitable. In full light the numerous signs of bias render the decision far more crafty than "crafted" (slip opinion at 13 [405 Mass. 112]).

[3] The board's expression of general and unsupported factual premises was another category of disturbing prejudice. In its decision it included a statistic that six percent of psychiatrists are believed to abuse patients (RA 88-89), an offering which never came into evidence (RA 580-582). It employed also the proposition that psychiatrists comprise a suspect class for the commission of sexual misconduct (RA 121-124). These statements reveal the board's apparent policy objective to discipline psychiatrists and to sacrifice to that end its obligation to adjudicate a case upon its merits.

consider a course to which it was fully alert from the beginning of its consideration of the case. The agency had its opportunity in abundance (16 months of original deliberation time) to follow the honest course of a remand. It could not resist the temptation of its prejudgment. For this reason in particular — the conscious rejection of a proper course for the sake prejudgment — it has forfeited its role as a constitutionally and statutorily required impartial decisionmaker.

5. *The exploitation of judicial review.* Under the present order of a remand, the board enjoys the process of judicial review as a safety net from which it can return to the mission after an unlawful adjudication. Extensive administrative litigation and two stages of judicial review in this court should not be practice rounds. The board has had excessive opportunity to decide the case properly. It is not entitled to litigate indefinitely until it learns how to give its prejudgment the right technical insulation against detectable legal error. Its deficiencies have now protracted the case by 32 months. It does not deserve any further extension for its own discredited performance or for the tribulation of the respondent physician.[4]

Moreover, the board now receives the opinion of the court as a blueprint not merely for the avoidance of error but also, in the circumstances of this case, for the accomplishment of a preconceived result. For the victim of prejudgment a remand is a futile remedy in the hands of the already committed decision maker.

---

[4] The events in question took place now almost 10 years ago. Doctor Morris has aged from 63 to 73. His career of 48 years of practice is free of any other complaint. The board commenced the proceedings in April of 1985; took 16 months to review the magistrate's decision, and caused an additional 16-month span of judicial review. Its possible remanded activity would mean additional indeterminate time in the board and in any necessary further judicial review. The entire pendency of a disciplinary proceeding exacts its own punitive toll from a respondent. At some point due process should mean final process.

The continuing pendency of the disciplinary prosecution subjects the physician to ongoing tribulation, delay, expense, loss of livelihood, personal and professional disrepute, and personal and family demoralization. The process itself is punitive and destructive of those itemized due process property and liberty interests of the individual confronting it. The board commenced this proceeding in April of 1985. Its legal errors have now wasted more than two and one-half years of that span and punished the physician throughout that duration. It is not entitled to pursue the effort any further.

6. *Conclusion.* An adjudicatory agency which has rendered detailed findings and rulings to the effect that legally insubstantial evidence constitutes overwhelming evidence of the ultimate facts of a case, and which has already rejected any need for the remanded factfinding ordered by the reviewing court, has irreparably prejudged the case. That prejudgment violates the presumption of impartial adjudication posited by *Withrow* v. *Larkin*, 421 U.S. 35, 55 (1975). It violates the due process guarantee of impartiality contained in Article 29 of the Declaration of Rights of the Massachusetts Constitution. It violates the Due Process Clause of the Fourteenth Amendment. As a

remedy, it requires the disqualification of the agency from any further consideration of the case and the reinstatement of the trial officer's recommended findings and decision as the untainted and final adjudication of the matter.[5]

Respectfully submitted,

/s/

Mitchell J. Sikora, Jr.,
Counsel to the Appellee
Thomas A. Morris, Jr., M.D.

MJS/amt
cc: Despena F. Billings
Assistant Attorney General
One Ashburton Place
Room 2019
Boston, MA 02108

Counsel for the Appellant Board
Registration in Medicine.

[5] Any remanded factfinding or explanation will bring the case back to the board for ultimate administrative decision and will therefore suffer from prejudgment. If the court continues to deem a remand permissible, it should at the least order any further factfinding to proceed before a magistrate of the independent Division of Administrative Law Appeals and prohibit factfinding by the board's employee hearing officers, as a minimal safeguard against influenced findings. This measure would mitigate, but not cure, the defect of prejudgment.

[Appendix to Petition for Rehearing by the Massachusetts Supreme Judicial Court (in pertinent part).]

A regular meeting of the Board of Registration was held on February 3, 1988, in Hearing Room C, 10 West Street, Boston, MA 02111.

Board Members present:

Andrew Bodman, M.D., J.D., Chairman
Marian Ego, Ed.D., J.D., Vice Chairman
Marianne Prout, M.D., Secretary
Ralph Deterling, M.D., Physician Member
Louise Liang, M.D., Physician Member
Dinesh Patel, M.D., Physician Member
Melinda Milberg, Esq., Public Member

* * * * *

Morris: Doctor Ego moved to adopt the recommended decision. Doctor Liang seconded the motion. Motion carried 6-0. Doctor Deterling abstained.

Appendix C.

[Denial of Rehearing by Massachusetts Supreme Judicial Court, Entered July 28, 1989.]

SUPREME JUDICIAL COURT FOR THE COMMONWEALTH

ROOM 1412 COURT HOUSE

BOSTON, MASSACHUSETTS 02108

JEAN M. KENNETT
Clerk

(617) 725-8055

FREDERICK J. QUINLAN
Assistant Clerk

July 28, 1989

Mitchell J. Sikora, Jr., Esq.
One Milk Street
Boston, MA 02108

Dear Attorney Sikora:

RE: SJC-4853
THOMAS A. MORRIS, JR.
vs.
BOARD OF REGISTRATION IN MEDICINE

Your request for rehearing filed in the above-captioned matter has been considered by the Court and is denied.

Very truly yours,

/s/
L. Holliey White
Assistant Clerk, pro tem

Appendix D.

[Order to Show Cause by Board of Registration in Medicine and Reference to Hearing Officer.]

COMMONWEALTH OF MASSACHUSETTS

BOARD OF REGISTRATION IN MEDICINE

SUFFOLK, SS. ADJUDICATORY CASE #

In the Matter of,

Thomas Morris, M.D. ORDER TO SHOW CAUSE
Respondent

The Board of Registration in Medicine (the "Board") has reason to believe that the above-named physician (the "Respondent") has failed to adhere to good and accepted standards in the practice of medicine.

The Respondent's conduct violates:

MGL ch. 112, sec. 5(c) and 243 CMR 1.03(5)(a)3, gross misconduct in the practice of medicine;

MGL ch. 112, sec. 5(h) and 243 CMR 1.03(5)(a)11, violating any rule or regulation of the Board governing the practice of medicine.

The Board's belief is based on the following information:

1. The Respondent is a duly licensed physician in the Commonwealth, specializing in psychiatry.

2. The Respondent maintains an office at 82 Marlborough Street, Boston, MA.

3. On or about May 17, 1977 the Respondent accepted as a patient, for therapy, Kathleen Martin. Ms. Martin was a patient of the Respondent until June, 1980.

4. In September, 1979 during the scheduled therapy session, at the Respondent's office, the Respondent initiated sexual relations with Ms. Martin.

5. From September, 1979 to November, 1979 the Respondent, during scheduled therapy sessions at his office, initiated sexual relations with Ms. Martin at least six times.

The Board is authorized to conduct an Adjudicatory Proceeding under 801 *CMR* 1.01 and has the power to discipline the Respondent under MGL chapters 30A and 112. Such discipline includes revocation, suspension or the censure and/or reprimand of the Respondent.

Wherefore, the Respondent is ordered to show cause why (s)he should not be disciplined for the above-stated reasons.

Date: April 17, 1985 /s/ _____

Marilyn Griffin, M.D.
Secretary of the Board
of Registration in Medicine

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss.

BOARD OF REGISTRATION
IN MEDICINE
Adjudicatory Case #

The Matter
of
Thomas Morris, M.D.

ORDER OF REFERENCE TO A HEARING OFFICER

At its meeting of April 17, 1985 the Board referred this case to the D.A.L.A.** to hear the case pursuant to the Standard Rules (801 C.M.R. sections 1.01 and 1.03) and to take evidence on all issues relevant and material to the charges brought against the Respondent and report the same to the Board together with findings of fact and a recommended decision including proposed conclusions of law.

Counsel are advised to file all original papers with the Board and provide the Hearing Officer and Complaint Counsel with copies addressed to them at their respective addresses as indicated below.

For the Board,

/s/ _____
Leonard J. Morse, M.D.
Chairman of the Board

Louis Scrima
Associate Complaint Counsel
Board of Registration in Medicine
100 Cambridge Street
Boston, MA 02202

**Division of Administrative Law Appeals
1 Ashburton Place
Room 1021
Boston, MA 02108

Appendix E.

[Doctor's Answer to Board's Order to Show Cause.]

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

DIVISION OF ADMINISTRATIVE LAW APPEALS
DALA Docket #BRD-8784

BOARD OF REGISTRATION IN MEDICINE, Plaintiff,	) DEFENDANT'S ANSWER TO PLAINTIFF'S ORDER TO SHOW CAUSE
v.	)
THOMAS MORRIS, M.D., Defendant/ Respondent.	)

The defendant/respondent, Thomas Morris, M.D., answers the Order to Show Cause issued by the plaintiff, dated April 17, 1985, as follows:

Defendant/respondent denies that he has failed to adhere to good and accepted standards in the practice of medicine.

Defendant/respondent denies that he violated M.G.L. Ch. 112, section 5(c) and 243 CMR 1.03(5)(a)3.

Defendant/respondent denies that he violated M.G.L. Ch. 112, section 5(h) and 243 CMR 1.03(5)(a)11.

1. Defendant/respondent admits the allegation contained in the paragraph numbered 1 of the Order to Show Cause.

2. Defendant/respondent admits the allegation contained in the paragraph numbered 2 of the Order to Show Cause.

3. Defendant/respondent admits the allegation contained in the paragraph numbered 3 of the Order to Show Cause.

4. Defendant/respondent denies each and every allegation contained in the paragraph numbered 4 of the Order to Show Cause.

5. Defendant/respondent denies the allegation contained in the paragraph numbered 5 of the Order to Show Cause. Further answering, defendant/respondent states that these allegations were the subject of a lawsuit recently concluded in the Hampshire County Superior Court (see attached Stipulation of Dismissal).

Further answering, defendant/respondent cites Affidavit of Kathleen Martin dated March 20, 1985, and letter of Attorney Edward Donnellan dated April 5, 1985, copies of which are attached hereto and made part hereof.

WHEREFORE, defendant/respondent Thomas Morris, M.D. requests that the Order to Show Cause be dismissed.

Thomas Morris, M.D.,
By his attorney,

/s/ _____

ELLIOT E. ROSENBERG
4 Longfellow Place, 37th floor
Boston, Massachusetts 02114
(617) 742-1810

Dated: May 9, 1985

Appendix F.

[Hearing Officer's Recommended Decision.]

SUFFOLK, ss. DIVISION OF ADMINISTRATIVE LAW APPEALS

Board of Registration in Medicine, Petitioner	)	Docket No. BRD-8784
v.	)	
Thomas Morris, M.D., Respondent	)	

Appearance for Petitioner:	Muriel Ann Finnegan, Esq. Associate Complaint Counsel 10 West St. Boston, MA 02111
Appearance for Respondent:	Elliot S. Rosenberg, Esq. 4 Longfellow Place — Suite 3703 Boston, MA 02114
Appearance for Kathleen Martin:	Judith Bowman, Esq. 133 Mt. Auburn St. Cambridge, MA 02138
Administrative Magistrate:	Joan Freiman Fink

RECOMMENDED DECISION

Pursuant to M.G.L. c. 112 §§ 5 and 61, the Board of Registration in Medicine (hereinafter "Board") issued on April 17, 1985 an order to show cause why Dr. Thomas Morris (here-

inafter Respondent) should not be disciplined "for failure to adhere to good and accepted standards in the practice of medicine." Specifically the Board charged that:

1) On or about May 17, 1977 the Respondent, a board certified physician specializing in psychiatry accepted as a patient for therapy, one Kathleen Martin. Kathleen Martin was a patient of the Respondent until June 1980.

2) In September 1979 during the scheduled therapy session at the Respondent's office, the Respondent initiated sexual relations with Kathleen Martin.

3) From September 1979 to November 1979 the Respondent during scheduled therapy sessions at his office, initiated sexual relations with Kathleen Martin at least six times.

On May 9, 1985 the Respondent filed an answer to the Board's Order to Show Cause. In this answer he denied the allegations in paragraphs 2 and 3 above and denied any other sexual relations with Kathleen Martin. In April of 1985 the Board referred the matter to the Division of Administrative Law Appeals for a hearing. A hearing pursuant to M.G.L. c. 7 § 4H and 801 CMR 1.01 was held on May 28, 1986. Subsequent days of hearing were held on June 17, 1986, July 1, 1986, July 14, 1986 and July 21, 1986.

The parties stipulated during the course of the hearing that sexual activity between a therapist and a patient during the course of a therapeutic relationship is not in keeping with accepted standards in the practice of medicine.

Various exhibits were entered into evidence (Exs. 1-15). Witnesses who testified at the hearing included Dr. Kathleen Martin, an assistant professor of psychology at Amherst College; Dr. Michael Perlman, a psychiatrist in private practice in Northampton, Mass.; Robert Cheney, a Catholic priest and University professor at Boston College; Dr. Thomas Morris, a licensed psychiatrist in private practice in Boston and the Respondent in the case; Dolores Morris, the Respondent's

wife; Katherine Liacos Izzo, a Superior Court Justice for the Commonwealth of Massachusetts; and Catherine Reissman, psychiatric social worker at the Harvard Medical School.

Kathleen Martin, a licensed psychologist and an assistant professor of psychology at University of Massachusetts and at Amherst College testified that during the period of September 1979 through November 1979 she and the Respondent engaged in sexual activity during the course of numerous therapy sessions. The Respondent denied these allegations and further denied having sexual relations with Kathleen Martin at any time.

The parties presented no witnesses who had directly observed any interaction between the Respondent and Kathleen Martin. Dr. [*sic*] Robert Cheney, a Catholic priest and a professor at Boston College, testified that he is a personal friend of Kathleen Martin. According to Father Cheney, during a conversation that he had with Dr. Martin on September 22, 1979, she informed him that she was having a sexual relationship with her therapist. Father Cheney further testified that she did not mention the therapist by name. In response to this information, Father Cheney advised her to terminate her relationship with this therapist.

Doctor Michael Perlman, a psychiatrist engaged in private practice in Northampton, Mass. testified that Kathleen Martin has been his patient from September of 1980 through the present date. Doctor Perlman noted that during the course of treatment, Kathleen Martin informed him that she had had sexual relations with the Respondent for a period of approximately six weeks in September and October of 1979.

Catherine Reissman, a psychiatric social worker employed at the Harvard Medical School and a personal friend of Kathleen Martin, testified that Dr. Martin discussed her decision to proceed against the Respondent in the Hampshire Superior Court with her and that the decision was a difficult one to

reach based on the potential effect the publicity surrounding the case could have on both her personal and professional life.

Dolores Morris, the Respondent's wife of 33 years, testified that she has had a continuous and normal sexual relationship with her husband during the course of their marriage. Katherine Liacos Izzo, a Superior Court Judge for the Commonwealth of Massachusetts, testified that prior to being appointed to the bench she was engaged in the practice of law and in that capacity represented Kathleen Martin in her child custody battle both in the Massachusetts Middlesex Probate Court and in the Probate Court in Cologne, West Germany. At the outset of Justice Izzo's testimony, Kathleen Martin raised the attorney-client privilege. Justice Izzo's testimony was then restricted to matters outside the scope of her attorney-client relationship with Dr. Martin and as such she was not permitted to testify as to statements that may have been made by Kathleen Martin concerning her relationship with the Respondent.

FINDINGS OF FACT

Based on the testimony and evidence provided, I make the following findings of fact:

1. The Respondent, Dr. Thomas Morris, was born in North Carolina on November 23, 1916 and graduated from Wake Forest College in 1937.

2. In 1941 he graduated from the University of Pennsylvania Medical School. After serving in the Medical Corps of the Navy from 1942 to 1947, he became a psychiatric resident in the Cushing Hospital in Framingham, MA.

3. In June of 1952 he became board certified in psychiatry and neurology and served on the staff at Peter Bent Brigham Hospital and Mass. Mental Health Center, of Harvard University Medical School from 1955 - 1972.

4. Since 1973 he has been engaged in private practice for psychoanalysis and psychotherapy at 82 Marlborough St. in Boston, Mass.

5. Doctor Kathleen Martin, a licensed psychologist in Massachusetts, received a bachelor of arts degree from DePaul University and a masters degree in educational psychology from the University of Minnesota. She received a doctorate degree in counseling from Boston College.

6. She first began to see the Respondent in a professional capacity for psychotherapy in June of 1977. She continued to see him approximately once a week for the period of June of 1977 through November of 1979 and then on occasion from January 29, 1980 through July 15, 1980. She had been referred to the Respondent by her advisor at Boston College.

7. Kathleen Martin sought treatment from the Respondent as a result of marital difficulties and a child custody problem.

8. Doctor Martin was married from 1968 until February of 1979 (the date the divorce was finalized) to Bernard Glvecklich, a physician from Cologne, West Germany.

9. In May of 1976 Dr. Martin was hospitalized for two weeks as a psychiatric inpatient at the Tufts New England Medical Center. This hospitalization occurred immediately subsequent to her having had an abortion in California.

10. In April of 1977, approximately one year after the date of her abortion she was hospitalized for a few days as a psychiatric inpatient at the Salem Hospital.

11. In early September of 1979, Kathleen Martin's ex-husband left the country with their daughter and took her back to Germany.

12. She was extremely upset by this set of circumstances and sought psychiatric counseling from the Respondent to assist her in dealing with this devastating personal crisis.

13. The parties agreed that for the period of September 7, 1979 through July 15, 1980, Kathleen Martin had the following 18 sessions with the Respondent:

Date of Session	Time	Place of Session
9/7/79	11:10 a.m.	office
9/12/79	5:10 p.m.	"
9/19/79	3:30 p.m.	"
9/25/79	1:50 p.m.	"
9/26/79	6:30 p.m.	"
10/3/79	4:20 p.m.	"
10/16/79	7:00 p.m.	"
10/24/79	6:00 p.m.	"
10/31/79	3:30 p.m.	"
1/29/80	1:50 p.m.	"
1/30/80	3:30 p.m.	"
2/4/80	7:30 p.m.	University Hosp.
2/6/80	8:30 p.m.	"
2/11/80	7:30 p.m.	11 Fairview St. Newton
6/11/80	3:30 p.m.	office
6/18/80	1:00 p.m.	"
6/23/80	11:10 a.m.	"
7/1/80	11:10 a.m.	"
7/15/80	11:10 a.m.	"

14. During the course of these sessions, Dr. Morris provided the Appellant with psychotherapy and counseling; and that no sexual contact occurred during any of these sessions.

15. Kathleen Martin filed an action against the Respondent in the Hampshire County Superior Court. (Docket No. 82-1694) This case was settled before completion of the trial and the action was dismissed with prejudice (see Ex. 4).

CONCLUSION AND RECOMMENDED DECISION

Pursuant to M.G.L. c. 112 § 5 the Board of Registration in Medicine, after investigating complaints against a registered physician relating to the proper practice of medicine and after

an adjudicatory proceeding pursuant to M.G.L. c. 30A may reprimand, censure, or otherwise discipline the physician.

In addition the burden of proof rests with the Board to demonstrate by a preponderance of the evidence that just cause exists to discipline the physician.

In the current case there is no material issue of law. The parties have stipulated that sexual activity between a therapist and a patient during the course of a therapeutic relationship is not consistent with acceptable medical practice. In addition there is no dispute that the relationship between the Respondent and Kathleen Martin was that of a therapist-patient. The central issue to be decided by the trier of fact concerns the sufficiency and credibility of the evidence against the Respondent.

During the course of her testimony, Kathleen Martin alleged that the Respondent initiated sexual activity during a therapy session that was conducted in early September of 1979 at a time that she was under extreme mental stress. This sexual activity, according to Kathleen Martin, continued once a week for a two and a half month period until November of 1979 at which time she left for Germany in an attempt to regain custody of her daughter.

The respondent strenuously denied each and every assertion. Rather he contended his conduct during the therapy sessions was totally professional and that he never engaged in sexual activity of any nature with Kathleen Martin.

The only direct testimony concerning whether any sexual activity occurred was provided by the Respondent and Kathleen Martin. There were no witnesses present at any of their therapy sessions nor were there any witnesses who observed any interaction between the two.

After reviewing all the testimony and evidence in this case, I conclude that the Board did not meet its burden of proof to show by a preponderance of the evidence that the Respondent engaged in any improper conduct at any time during the course

of his therapeutic relationship with Kathleen Martin. This conclusion is based in part on my finding that the testimony of the Respondent was more credible than Kathleen Martin's testimony.

During the five days of hearing, I had ample opportunity to observe the demeanor of the witnesses including their appearance and general bearing. In addition I had an opportunity to consider the general tenor of their testimony. See *Connor* v. *Connor*, 77 A.2d 697 (1951) where the Pennsylvania Court held that the "opportunity to observe demeanor and appearance of witnesses in many instances becomes the very touchstone of credibility." See also *Christie* v. *Eager*, 26 A.2d 352 (1942) *State* v. *James*, 206 A.2d 410 (1965).

I find the Respondent to be a compelling and credible witness and further find that his testimony denying the allegations of sexual impropriety was more likely than not to be true. Conversely, while I sympathize with Dr. Martin concerning her difficult domestic problems, nonetheless I find that her uncorroborated and unsubstantiated testimony relating to her repeated sexual encounters with the Respondent was not convincing.

The only charges involved in this case concern the allegations of sexual impropriety against the Respondent. In accordance with my findings, I conclude that the Board did not meet its burden of proof to demonstrate that the Respondent acted in a manner inconsistent with accepted medical practice.

I thus conclude that the Board of Registration in Medicine has no just cause to discipline the Respondent and recommend that the Board dismiss the charges pending against him.

DIVISION OF ADMINISTRATIVE LAW APPEALS

Joan Freiman Fink
Administrative Magistrate

JF:kl
Dated: September 18, 1986

Appendix G.

[Final Decision and Order of the Board of Registration.]

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS.

BOARD OF REGISTRATION IN MEDICINE

ADJUDICATORY CASE NO. 85-18
(DALA-BRD. 8784)

In the Matter of
THOMAS MORRIS, M.D.

FINAL DECISION AND ORDER

Appearances: Muriel Ann Finnegan, Esq. for the Board of Registration in Medicine
Elliot Rosenberg, Esq. for the Respondent
Judith Bowman, Esq. for the Patient

I. Summary of Proceedings

This case was commenced by Order to Show Cause, dated April 17, 1985 (Exhibit 1), in which the Board of Registration in Medicine (the "Board") alleged that Thomas Morris, M.D. (the "Respondent") violated M.G.L. Ch. 112, sec. 5(c) and 243 CMR 1.03(5)(a)(3) (committed gross misconduct in the practice of medicine) and M.G.L. Ch. 112, sec. 5(h) and 243 CMR 1.03(5)(a)(11) (violation of the Board's rules and regulations). Specifically, the Board alleged that the Respondent

initiated sexual relations with a patient, hereinafter referred to as "Patient," on at least six occasions from September to November, 1979.[1]

On April 17, 1985, this matter was referred to the Division of Administrative Law Appeals ("D.A.L.A.") for a hearing (Exhibit 3). The Respondent filed an Answer (Exhibit 2) denying the allegations of misconduct on May 9, 1985.

Hearings in this matter were before Administrative Magistrate Joan Freiman Fink. They commenced on May 28, 1986, and were continued to June 17, July 1 and July 14, 1986 and concluded on July 21, 1986.[2] The Board Prosecutor requested a tentative decision and filed objections upon receipt of the tentative decision. The Administrative Magistrate filed a Recommended Decision, dated September 18, 1986, with the Board, a copy of which is attached as Exhibit "A."

In her Recommended Decision, which we reject on the basis of the overwhelming evidence in the record, the Administrative Magistrate found that the Board did not prove sexual misconduct by the Respondent in the context of his psychiatric relationship with the Patient. The Magistrate's determination appears to be based largely on a subsidiary finding that the Respondent's demeanor was more believable than the Patient's. (Recommended Decision, pp. 8-10)

The Board Prosecutor renewed her objections to the Recommended Decision before the Board. Pursuant to a Board Order of March 18, 1987, the Board Prosecutor submitted a more

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[1] The identity of the patient has been withheld and a pseudonym used to protect the patient's confidentiality and privacy. This is consistent with the prior ruling of the hearing officer to keep the testimony and exhibits confidential during the course of the proceedings below.

[2] There is a discrepancy between the hearing dates set forth in the Recommended Decision and the record transmitted in this matter. The transcript prepared from the recording of the second day of hearing is dated June 16, 1986. The Recommended Decision dates the hearing on June 17, 1986. We adopt the version in the Recommended Decision.

detailed Memorandum in support of her objections, which contained appropriate references to the transcript of the proceeding. The Respondent did not file a reply.

II. Summary of Evidence Presented

The following is a brief description of the relevant evidence presented:

The Associate Prosecutor offered the testimony of the following witnesses:

(a) Patient, concerning the circumstances leading to her professional relation with the Respondent including her marital difficulties and child custody dispute, her care and treatment by the Respondent between September and November, 1979, including sexual relations with the Respondent and events subsequent to November, 1979 relating to the allegations of sexual misconduct;

(b) Michael Perlman, M.D., the Patient's treating psychiatrist from September, 1980 to the date of the hearing, concerning the Patient's disclosures of sexual relations with the Respondent, and his opinions concerning sexual relations between a psychiatrist and a patient;

(c) Robert Cheney, priest and Boston College professor, concerning his relationship with the Patient and her September 22, 1979 disclosure of sexual relations with her therapist;

(d) Catherine Reissman, a psychiatric social worker, concerning discussions with the Patient about the difficulties in litigating her claim of sexual misconduct against the Respondent, including the impact of trial publicity on the Patient's personal and professional life;

The Respondent offered the testimony of the following witnesses:

(a) The Respondent, concerning the history of the Patient, his care and treatment of the Patient, the events surrounding his care and treatment between September, 1979 and November, 1979, including the allegations of sexual relations with the Patient, his involvement in the Patient's child custody dispute and his opinion of the propriety of sexual relations between a psychiatrist and a patient; and

(b) Honorable Justice Catherine Liacos Izzo, former attorney for the Patient and presently a Justice of the Superior Court of the Commonwealth of Massachusetts, concerning non-privileged matters arising out [of] her representation of the Patient in her divorce proceedings and child custody dispute, and the involvement of the Respondent in these legal matters;

(c) Delores Morris, the wife of the Respondent, concerning her sexual relations with her husband and family matters at issue in the case.

The following documentary evidence was introduced by stipulation of the parties:

Exhibit 1: Order to Show Cause in this matter, dated April 17, 1985;

Exhibit 2: Defendant's [Respondent's] Answer to Plaintiff's Order to Show Cause, dated May 9, 1985;

Exhibit 3: Order of Reference to a Hearing Officer in this matter;

Exhibit 4: Stipulation of Dismissal with Prejudice in a civil action brought by the Patient against the Respondent, dated March 20, 1985;

Exhibit 5: Statement, signed by the Patient, dated March 20, 1985; and

Exhibit 13: Records from McLean Hospital relating to the Respondent.

The Associate Prosecutor presented the following documentary evidence:

Exhibit 7: Curriculum Vitae of Michael Perlman, M.D.;

Exhibit 13: Records from McLean Hospital relating to the Respondent;

Exhibit 14: Defendant's [Respondent's] Answers to Interrogatories in a civil action brought by the Patient against the Respondent;

Exhibit 15: Summary of Patient's visits to the Respondent from September 7, 1979 to July 15, 1980.

The Respondent presented the following documentary evidence:

Exhibit 6: Letter, dated November 2, from the Patient to the Respondent, with envelope addressed to the Respondent;

Exhibit 8: Letter, dated July 26, 1977 from the Respondent to Sister Patricia Milliken;

Exhibit 9: Letter, dated July 18, 1978, from the Respondent to Sister Patricia Milliken;

Exhibit 10: Letter, dated October 2, 1979, from Katherine Liacos Izzo of Liacos and Liacos to the Respondent, with a handwritten response from the Respondent;

Exhibit 11: Letter, dated October 12, 1979, from the Respondent to Katherine Liacos Izzo of Liacos and Liacos; and

Exhibit 12: Letter, dated March 18, 1980, from David Engle, Esq., Assistant Director of the Mental Health Legal Advisors Committee, to the Respondent.

III. Findings of Fact

We base our findings of fact on the record transmitted from D.A.L.A., including the exhibits enumerated above, verbatim recordings of the proceedings and the findings contained in the Recommended Decision. To the extent that we make findings different from those in the Recommended Decision, reasons have been provided:

1. We adopt paragraph 1 of the Findings of Fact set forth in the Recommended Decision and re-state the prior finding below, together with transcript references in support of the findings.[3]

The Respondent, Dr. Thomas Morris, was born in North Carolina on November 23, 1916 and graduated from Wake Forest College in 1937. (Vol. II, 118) (Exhibit 13)

2. We adopt paragraph 2 of the Findings of Fact set forth in the Recommended Decision and restate the prior finding below, together with transcript references in support of the finding;

In 1941 he graduated from the University of Pennsylvania Medical School. After serving in the Medical Corp. of the Navy from 1942 to 1947, he became a psychiatric resident in the Cushing Hospital in Framingham, Massachusetts. (Vol. II, 118-119) (Exhibit 13)

3. We adopt paragraph 3 of the Findings of Fact set forth in the Recommended Decision and re-state the prior finding

[3] For the purpose of citation, the transcripts from the five hearing dates have been designated as follows: May 21, Vol. I; June 17, Vol. II; July 1, Vol. III; July 14, Vol. IV; and July 21, Vol. V.

below, together with transcript references in support of the finding;

In June 1952, he became board certified in psychiatry and neurology and served on the staff at Peter Bent Brigham Hospital and Mass. Mental Health Center, of Harvard University Medical School from 1955-1972. (Vol. II, 119) (Exhibit 13)

4. We adopt paragraph 4 of the Findings of Fact set forth in the Recommended Decision, but make supplemental findings and add appropriate transcript references. For the sake of clarity in making this findings, we will re-state the prior finding herein.

Since 1973, the Respondent has been engaged in private practice for psychoanalysis and psychotherapy at 82 Marlborough Street, Boston, MA. (Vol. II, 119-120) (Exhibit 13) In 1977, the Respondent and his wife relocated from Newton to Westport, a farming community between the New Bedford and Fall River. (Vol. III, 9, 13-14) By the fall of 1979, the Respondent was still in the process of winding down his practice in Boston and establishing a practice in southeastern Massachusetts. (Vol. II, 119-120) Instead of commuting to Boston, the Respondent in the fall of 1979 spent at least three or four days per week away from his New Bedford home to maintain his Boston practice. While on these weekly excursions, he would stay with family members in the surrounding Boston area. (Vol. III, 10-14)

5. We adopt paragraph 5 of the Findings of Fact set forth in the Recommended Decision, but make corrections to change inaccuracies, make supplemental findings and add appropriate transcript references. For the sake of clarity in making this findings, we will re-state the subtance of the prior finding herein.

At the time of the hearing, the Patient was eligible to be licensed as a clinical psychologist in Massachusetts and was

teaching in the Psychology Department of the University of Massachusetts, Amherst. She received a bachelor of arts degree from Depauw University, Indiana, a masters degree from the University of Minnesota, and a doctorate degree in counselling from Boston College. She did pre-doctoral and post-doctoral training at Solomon Carter Fuller Mental Health Center and Dartmouth Hitchcock Medical Center, New Hampshire. (Vol. I, 14, 20-21)

6. In this finding and the findings set forth below, we generally adopt paragraphs 6 through 13, inclusive, of the Findings of Fact set forth in the Recommended Decision with minor changes noted below to reflect the evidence presented. Supplemental findings and appropriate transcript references have been added. For the sake of clarity in presenting our findings, we will re-state the prior findings in the context of our findings.

The Patient was married to Bernard Glvecklich, a physician from Cologne, West Germany, on December, 1968. (Vol. I, 22-23) In 1972, a child, Erin, was born of the marriage (Vol. I, 22) (Ex. 9)

7. In May, 1976, the Patient was hospitalized as a psychiatric inpatient at the Tufts New England Medical Center and was transferred to Westwood Lodge pursuant to G.L. c. 123, sec. 12. This hospitalization occurred immediately after the Patient had an abortion in California. (Vol. I, 69-70, 74-79; Vol. II, 125) (Ex. 9)

8. From April 25, 1977 to May 16, 1977, the Patient was hospitalized as a psychiatric inpatient in the Salem Hospital and during that stay, committed to Glenside Hospital. (Vol. I, 81-83) (Ex. 9)

9. We include the general findings relating to the Patient's past mental history, since they are part of the history given the Respondent. (Vol. II, 124-128) However, we believe the

Magistrate should have more closely controlled the admission of this highly personal evidence. (Vol. I, 59-83) The extensive evidence received on this subject was wholly disproportionate to its conceivable relevance. Even though the Magistrate did not expressly rely on this evidence, its admission created the danger that this unwarranted intrusion could affect the Patient's demeanor. Such evidence is of value only insofar as it can be said to affect a witness' capacity to perceive, remember and articulate correctly. *See Commonwealth* v. *Caine*, 366 Mass. 366, 369 (1974); *Commonwealth* v. *Butler*, 331 A.2d 678, 680 (Pa. Super., 1974) (exclusion of questions concerning prior psychiatric hospitalizations of witnesses was proper) Here, as in *Caine* and *Butler*, evidence of the witness's prior psychiatric treatment had no tendency to show impairment of the witness' ability to perceive, remember or articulate the events in question. The hospitalizations were not connected with eventual reasons for treatment by the Respondent. Neither the reasons for hospitalization nor the treatment the Patient received appeared to relate to her testimonial capacity. Also the treatment was removed in time from the events at issue. From 1977 to the date of her testimony, she had not had a psychiatric hospitalization. (Vol. II, 46) There is no indication that she suffered from hallucinations, delusions or similar disturbance. *See* paragraph "21" below. Whatever probative value the evidence could be given, this was completely overshadowed by the invasive nature and possible prejudicial effect of this extensive evidence. *See* Paragraph "28" for discussion of prejudicial effect.

10. In 1976, her marriage began to deteriorate when her husband failed to pass a qualifying examination to practice medicine. According to the Patient, he began self-prescribing amphetamines and his behavior became abusive and paranoid. (Vol. I, 23-24)

11. Sometime around June, 1977, the Patient had separated from her husband. She was protected by a restraining order and had custody of her child, Erin. (Vol. I, 86-87)

12. Later, in mid-August 1977, the Patient engaged Katherine Liacos Izzo, Esq. (hereinafter referred to as "Attorney Izzo")[4] to represent her in connection with a divorce and custody matters. (Vol. IV, 5, 11)

13. The Patient was referred to the Respondent by Dr. Hurwitz, her advisor for her doctoral dissertation. (Vol. I, 84-85; Vol. II, 122)

14. Beginning in May, 1977, she began seeing the Respondent in a professional capacity for psychotherapy on a weekly basis. (Vol. I, 25-26; Vol. II, 128-129)

15. The Patient sought treatment from the Respondent for anxiety arising out of her deteriorating marriage and child custody issues involving Erin. (Vol. I, 27-28; Vol. II, 122-123)

16. During the Patient's treatment and prior to her divorce, the custody of Erin was contested and actual physical custody see-sawed back and forth between the Patient and her husband. (Vol. I, 95)

17. On the first visit, the Patient provided the Respondent with a detailed treatment history and the background information to her immediate treatment problems. (Vol. II, 124-128) Paragraphs "6" through "12" above, inclusive, cover the matters recounted to the Respondent.

18. On the basis of this interview and the review of medical records and reports concerning the Patient's prior treatment,

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[4] This denomination is intended to reflect only the role of the Justice Izzo at the time the events in this case which occurred prior to her appointment to the bench.

including hospitalization and lithium treatment for manic depressive illness, the Respondent formulated a working diagnosis. (Vol. II, 129)

19. His impression of the Patient was that she suffered a psychlothymic type of illness characterized by mood swings. (Vol. II, 129) At this stage, hers was a milder, non-psychotic form of affective disorder distinct for manic depressive illness. (Vol. II, 132) Her episodes of feeling high, according to the Respondent, could be evidenced by volubility; formation of inappropriate relationships; becoming involved in situations "with a high risk of failure, but sometimes a high chance of success"; difficulty sleeping and racing thoughts. In the depressed phase, the person may exhibit appetite loss, "over-eating or under eating, over-sleeping or under sleeping," difficulties performing work or concentrating, and absence of pleasure from recreational or other activities. (Vol. II, 129-132) (Vol. III, 80)

20. From the time her treatment commenced in 1977 to late January, 1980, the Respondent never saw the Patient in a manic state. (Vol. II, 133) It was only after her return from Europe in late January, 1980 that the Respondent saw her in this condition.[5] (Vol. II, 133)

21. The Respondent had no evidence that the Patient, during her treatment, suffered from hallucinations, delusions or similar thought disturbances. (Ex. 8) (Ex. 9) (Vol. III, 80) Nor was there any evidence that she suffered such disturbances.

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[5] We are unable to determine the precise date of this encounter, because of discrepancies in the record. The Respondent testified that he first saw the Patient after her return on January 30, 1980, because a late flight had forced cancellation of an appointment the day earlier. However, according to the parties' stipulation, she was seen on January 29, 1980. We do not pursue this matter, since it is collateral.

22. There was no credible evidence that the Patient was unable to distinguish fact and fantasy in her relation of events (Vol. I, 104). She was not suffering from a disorder which affected or distorted her thinking process. In particular, the detail provided by the Patient concerning the episodes of alleged sexual misconduct, together with the evidence that she had given Dr. Perlman and Father Cheney similar accounts, convinces us that she did not fantasize these events.

Also, the Respondent acknowledged that, on many issues, he believed the Patient to be an accurate historian. Specifically, he believed that the Patient's account of family and personal background, and in particular the history of physical abuse by her husband. (Vol. III, 22)

Moreover, in the five years of his treatment, between 1980 and 1985, Dr. Perlman never saw the patient psychotic or delusional. (Vol. II, 76-77)

23. At the time the Respondent began treating the Patient, she had recently received Dalmane, 30 mgm. at bedtime for insomnia and was receiving Valium, 5 mgm., twice daily for anxiety.

She had previous trials on lithium which created undesirable side effects, including blurred vision, weight loss, tremors, poor coordination, lethargy and one "seizure-like" episode. (Ex. 9) (Ex. 14) (Vol. III, 81)

24. The Respondent discontinued the Valium in the belief that this "might be a possible cause for her depressive feelings." (Ex. 8) (Ex. 14) On different occasions he attempted to prescribe Lithium to the Patient, but she refused. She was prescribed Dalmane in the fall of 1979 for insomnia. Earlier in the summer, he prescribed Nardil, an anti-depressant. The Patient responded in 2 to 3 weeks, and became more energetic and less lethargic. (Ex. 14) (Vol. II, 81)

25. The focal point of the Patient's therapy sessions with the Respondent centered on marital and custody issues. (Vol. I, 27, 86; Vol. II, 123, 129-130; Vol. III, 24-25, 52) The Respondent observed that the Patient needed assistance most in dealing with "the circumstantial problems of everyday life" arising out of marital discord and child custody issues. (Vol. II, 129-130) Consistent with this focus, the Respondent classified the Patient as suffering from adult situational stress, for Blue Shield billing purposes. (Vol. II, 131)

26. Throughout her therapy sessions, issues relating to the Patient's sexual behavior were not of primary significance. (Vol. I, 86) The Respondent testified that he could not recall ever asking her questions about her sexual relations, although the Patient did discuss her past relationships. (Vol. III, 24-25, 37) Among issues discussed were the effect of the Patient's divorce on her sexual relations. (Vol. II, 44)

27. Among the relationships she discussed, the Patient informed the Respondent of her relationship with Dr. S., a work colleague at Boston University. According to the Patient, the Respondent had an interest in this relationship which the Patient characterized as "nice" and which involved sexual relations. (Vol. I, 102, 112-113; Vol. II, 160-162)

28. Allowing great latitude in cross examination to test credibility is appropriate (Vol. I, 105), but the Magistrate exceeded her discretion in permitting the Respondent's counsel unfettered latitude to inquire into minute details of the Patient's sexual history. (Tr. Vol. I, 86-120) As a result, highly prejudicial evidence, of questionable relevance, was admitted, despite doubts expressed by the Magistrate herself as to the relevance of such inquiry. (Tr. Vol. I, 102, 104, 106) We are concerned that the Magistrate by permitting this inquiry improperly shifted the focus from the Respondent's alleged miscon-

duct to the issue of a consensual relationship between the Respondent and the Patient. As stipulated by the parties and supported by the testimony of the Respondent and others, a psychiatrist, who has sexual relations with a patient, has committed misconduct, regardless of whether the patient consents. Also, in view of this improper line of inquiry, there is considerable reason to question the Magistrate's rejection of the Patient's testimony on the basis of "demeanor," "appearance" and "general bearing."

Repeated examination concerning the Patient's sexual history included questions asking the Patient to verify a 1977 incident in which she spent an afternoon in a hotel having sexual relations with a friend. (Vol. I, 94) In this vein the Respondent's Counsel pursued the following colloquy with the Patient:

Q. Did you — I'll make if specific: Did you engage in sexual activity with casual acquaintances?
A. No, I did not.
Q. Is your testimony that the only time that this ever happened was on this one occasion that you've just told us happened?
Q. I guess I'm going to have to talk about dates in here. Are you getting at whether I was separated or not separated? Is that the issue?
Q. No, I am not; I am asking you — you've told us that — I believe you've told us that one episode in 1977 of a sexual nature with a person not your husband —
A. That's right.
Q. — and not previously known to you occurred; is that correct?
A. That is right. The abortion —
Q. Now, just a moment; if that is right, now I ask you, prior to the end of 1977 on how many other occasions

did this sort of an encounter, a sexual encounter with someone not previously known to you, occur?

A. Not previously known to me? This man was a neighbor. What do you mean "not previously known to me"?

Q. Did you meet this man by prearrangement?

A. This is outrageous, Mr. Rosenberg. I have no idea what you're asking me. What man are you talking about? Would you give me a specific? I have no idea what you're asking me. (Vol. I, 92-93)

Upon further questioning, she was asked to disclose her relations with an English friend who fathered her child (Vol. I, 96-97, 110-111) a work colleague at Boston University in 1978 (Vol. I, 101-103, 111-112) and a Spanish American psychologist. (Vol. I, 114-119) In regard to the latter relationship, the following exchange was allowed:

Q. Did you have sexual intercourse with this Spanish gentleman that you've described?

A. Yes.

Q. On how many occasions?

A. Two or three.

Q. Now, in your mind, would you call having sexual intercourse with a specific individual a "sexual relationship?"

A. It was a sexual friendship in that case. It was as sexual friendship.

Q. And you distinguish that from a sexual relationship?

A. Yes. If someone attacks me, if someone assaults me it is not a sexual friendship. (Vol. I, 118-119)

None of these persons nor their relations with the Patient were connected in time or other manner with events alleged in

the Order to Show Cause. Respondent's offers to show the relevance of this evidence was weak. The suggestion that sexual history is tied to a witness's veracity is unsupported. (Tr. Vol. I, 89-90) Nor were the responses to such questions relevant to show that the Patient was unable to distinguish between facts and fantasy in her sexual experiences. (Vol. I, 104)

Given that the Magistrate, herself, expressed doubts as to the relevance of such evidence (Vol. I, 104), we are at a loss to understand why extensive testimony was received in this regard. Certain comments of Respondent's counsel on the value of this evidence should have provided insight into the real purpose of the inquiry.

> We are talking about an allegation of consensual sexual activity between two people which is denied. And I think that both the psychiatric condition of the person making the allegations and the history of the person making the allegations is pertinent, especially in view of the special circumstances here of the admitted pregnancy of this woman by a third party during the period . . . (Vol. I, 88)

The Respondent's counsel relies on a theory of the case, the issue of consent, which is wholly inapplicable. When considered in connection with his concern about her pregnancy out of wedlock, it should have been apparent that the Respondent sought to discredit the Patient by making her appear promiscuous. The Respondent was trying to show a history of casual sex, to suggest that, even if he had a sexual contact with the Patient, it was at her initiative or she could not have suffered any harm. It that was the Respondent's legal strategy, we must emphasize the fact that this is not a legally tenable defense to sexual contact with a patient. *In the Matter of Eric Fredrickson*, No. 87-47-HY (Board of Registration in Medi-

cine Dec. 9, 1987) (Final Decision and Order). We further note that the parties had stipulated that a psychiatrist acts improperly simply by having sexual relations with a patient.

Moreover, since this point was developed, there is an equally plausible inference that the Respondent, knowing of this history, sought to exploit it for his personal benefit.

In analyzing the type of inquiry which should have been allowed, the criminal standard offers some guidance. Where questioning on cross-examination is connected to the sexual conduct of a victim, the cross-examining counsel should have a clear reason for asking such questions and should be prepared to disclose that reason to the judge. *See Commonwealth* v. *Chretien*, 383 Mass. 123 (1981); *Commonwealth* v. *Bohannon*, 376 Mass. 90, 95 (1978). The policy to tighten the reins in a case alleging sexual abuse is valid whether or not the case involves criminal charges. In fact, since consent is not an issue in cases of sexual relations with a patient, there is stronger justification to exclude such evidence. In any case, the admission of such testimony creates the risk that a decision will be made on an improper basis.

This standard promotes an important policy objective of the Board to protect the privacy and dignity of patients who bring complaints before it. *In the Matter of Richard Adams*, No. 87-11-CA. (Board of Registration in Medicine, November 6, 1986) (Final Order of Summary Suspension). It recognizes the plight of victims of alleged sexual abuse, who are not themselves on trial and should not be made "fair game for character assassination." Any other approach would unduly discourage the filing of sexual abuse complaints, while offering the Board negligible or totally irrelevant evidence on the issues it must decide.

Whatever marginal relevance such inquiry arguably might have had, the prejudice caused by such testimony can be significant. The proceedings contained irrelevant inquiries con-

cerning the Patient's relationships with several men and the paternity of her son Andrew, which continued during the direct examination of the Respondent. (Tr. Vol. I, 90-120) (Tr. Vol. II, 159-166) The questioning might have allowed the Magistrate to draw the unfair inference that the witness was not to be believed because of her sexual history. *See Commonwealth* v. *Bohannon*, 376 Mass. 90, 95 (1978) (witness should not be impeached by the introduction of prior bad acts or reputation for unchastity). Also, this unfair questioning may have been responsible for legitimate or understandable changes in the witness's demeanor which the Magistrate later relied on "in part" to discredit her testimony.

29. From 1977 to Spring of 1979, the Respondent generally saw the Patient on a regular basis for fifty minute sessions. At certain times, her visits became sporadic. (Vol. II, 133-134)

30. As her treating psychiatrist, the Respondent became involved in the Patient's custody dispute. He participated in the legal proceedings in the Essex County Probate Court by writing reports, providing testimony and serving as Guardian ad Litem [*sic*]. (Vol. I, 28; Vol. II, 134-147; Vol. IV, 25-26) (Ex. 8) (Ex. 9) (Ex. 10) (Ex. 11)

31. In two letters to the Guardian ad Litem, Sister Patricia Milliken, the Respondent stated that the Patient was fit to care for her child (Ex. 8) (Ex. 9). In a letter prepared for the Court, in 1979, the Respondent reiterated his belief in the Patient's mental and emotional capacity to care for her child. (Ex. 11)

Assuming that Exhibit 8 was only an original draft, that it had not been filed with the Essex County Probate Court and had never been shown to the Patient prior to its introduction into evidence (Vol. V, 38-41), we do not believe that its reliability is seriously undercut by these considerations.

32. In 1978, the Respondent provided the following testimony on the Patient's behalf:

> The substance and thrust of my testimony was that, although there'd been a past psychiatric history of severe illness, that during the course of her treatment with me up till that time, there had been no evidence of severe impairment for psychiatric reasons, and that mainly what I had seen, that when she had her child, had her child in her custody and was free from threats from her husband, and that when she had adequate financial support, that she was in a very stable condition. (Tr. Vol. II, 142)

33. The Patient's divorce from her husband became final in August, 1979. (Tr. Vol. I, 131)

34. At that time, the child's father was granted custody and the Patient was granted visitation rights. (Vol. I, 131-132) Her former husband had custody of Erin with an understanding that he was not to remove her from the Commonwealth. (Tr. Vol. I, 133)

35. In August or September, 1979, the Patient's former husband, having immediately remarried, took their daughter, Erin, to Germany without telling the Patient. (Tr. Vol. I, 30-31, 132-133).

36. The parties agreed that from September 7, 1979 to July 15, 1980, the Respondent saw the Patient on the following occasions (Ex. 15):

Fri.	9/7/79	11:10 a.m.	office
Wed.	9/12/79	5:10 p.m.	office
Wed.	9/19/79	3:30 p.m.	office
Tues.	9/25/79	1:50 p.m.	office
Wed.	9/26/79	6:30 p.m.	office
Wed.	10/3/79	4:20 p.m.	office

Tues.	10/16/79	7:00 p.m.	office
Wed.	10/24/79	6:00 p.m.	office
Wed.	10/31/79	3:30 p.m.	office
Tues.	1/29/80	1:50 p.m.	office
Wed.	1/30/80	3:30 p.m.	office
Mon.	2/4/80	7:30 p.m.	University Hospital
Wed.	2/6/80	8:30 p.m.	University Hospital
Mon.	2/11/80	7:30 p.m.	Home: 11 Fairview St. Newton, MA
Wed.	6/11/80	3:30 p.m.	office
Wed.	6/18/80	1:00 p.m.	office
Mon.	6/23/80	11:10 a.m.	office
Wed.	7/1/80	11:10 a.m.	office
Tues.	7/15/80	11:10 a.m.	office

37. We reject paragraph 14 of the Findings of Fact set forth in the Recommended Decision for the reasons stated below. As more fully set forth in section entitled "Conclusions of Law," the evidence viewed as a whole, particularly with the benefit of transcripts unavailable to the Magistrate, does not support her finding that no sexual relations took place. It is critical to note that the Magistrate based this finding only "in part" on her assessment of "credibility," but her Recommended Decision gives no hint as to what else she relied upon. We recognize that a credibility determination is pivotal to the disposition of this matter and the Magistrate has the primary role in this determination. However, the Recommended Decision failed to take into consideration all of the factors which affect such a determination which, if fully considered, show that the preponderance of the evidence supports the subsequent findings.

In particular, the Recommended Decision is silent on critical evidence in the record. In neither its Findings of Fact nor its Conclusion and Recommended Decision does the Recommended

Decision analyze or weigh overwhelming and often undisputed evidence, such as the corroborating testimony of Father Cheney showing a "fresh complaint," the corroborating testimony from the Patient's own psychiatrist, the undisputed facts that the Respondent made at least one (and we conclude more than one) house call(s), that he provided her with a "therapy session" in his car, that he dined alone with the Patient, that they had personal financial dealings, and the potential adverse effect of the unwarranted questioning on the Patient's demeanor. Perhaps the Hearing Officer had some thoughts about these facts or had in her own mind made inferences therefrom, but she did not share them with the Board. Instead, her ultimate conclusions are derived entirely from unarticulated observations of witness "demeanor" and a concern that there was no eyewitness other than the Patient to any sexual misconduct. The preoccupation with the absence of other eyewitnesses is misplaced. It would be rare for a third party to be present under the circumstances of this case. The inadequacy of the Hearing Officer's findings are more fully detailed below.

If the record did not contain, as it does, the overwhelming evidence of sexual misconduct, we would remand this case for further proceedings and findings.

38. All who testified were in agreement that sexual relations between a psychiatrist and a patient is a substantial deviation from good and accepted medical care. As noted in the Recommended Decision (p. 8), the parties also stipulated that sexual activity during the course of therapy was not consistent with acceptable medical practices.

Specifically, Dr. Perlman opined that the care provided by a psychiatrist, who engages in sexual relations with a patient, is substantially below the standards of good and accepted psychiatric care. Furthermore, Dr. Perlman observed that the ethical canons of American Psychiatric Association explicitly for-

bid such conduct. This conduct is wrong because it destroys the therapeutic trust and security necessary for a patient to reveal her innermost feelings and it places the psychiatrist's interests ahead of his patients. (Vol. II, 79-80)

The Respondent concurred in the opinion that sexual relations between a treating psychiatrist and the patient are "improper, unprofessional, unethical." (Vol. II, 153)

39. The problem of sexual abuse in these types of cases is significant. As he testified, the Respondent was familiar with the literature concerning sexual relations between psychiatrist and patient. He acknowledged that studies have confirmed the existence of the problem and one study cited six percent of psychiatrists are offenders. (Vol. III, 49-50)

40. The Patient's life was cast into turmoil by the removal of her daughter. She initially did not know where her daughter was. She was frightened for her daughter. She was at a loss as to how she should proceed. (Vol. I, 31)

41. During this time, the Patient used her therapy sessions with the Respondent to deal with the personal crisis caused by the removal of her child and the loss of visitation. (Vol. I, 30-31; Vol. III. 24-25)

42. During therapy sessions between September and October 31, 1979, according to the Respondent, the Patient was obsessed with regaining custody of her child. It was "a crescendo of trauma building up since she first lost custody." (Vol. III, 64) She was concerned with every facet from obtaining money to fund her efforts to learning the international law on the subject. (Vol. III, 24-25, 53, 65-67) The Respondent testified that the Patient could not be distracted from repeatedly discussing the same matters over and over again:

> Over and over. "I want my child back. If I get my child back everything's going to be all right." Any proposals or attempts to get her away from this particular subject always came back to that. (Vol. III, 67)

He further testified that unlike his other patient relationships, "a great deal of [his] time and effort went into trying to help [the Patient] resolve the custody fight over her child." (Vol. III, 38) According to the Respondent, he noted that she exhibited grief, mainfested by frequent crying during sessions. (Vol. III, 52-53)

43. During an appointment within two or three weeks of the removal of Erin, in early September, 1979, the Respondent engaged in sexual activity with the Patient. This encounter occurred during an afternoon session in his office; the Respondent had another patient scheduled next. (Vol. I, 32, 137) According to the Patient, the Respondent commented that "there was nothing more he could do for [the Patient] than offer [her] physical comfort." (Tr. Vol. I, 30) At this time, he left the chair where he usually sat during these sessions and approached the chair where the Patient customarily sat. (Vol. I, 26, 30) After sitting on the arm of the chair, the Respondent began stroking the Patient and invited her to lie down on the couch of the room. (Vol. I, 30-31) She was unclear as to his intentions at this point. He then spread a blanket on the floor and began to undress. He attempted to have sexual intercourse. (Vol. I, 31-32) (Vol. II, 48-50)

44. The Patient's initial reaction to the Respondent's overtures was one of being "astounded, bewildered." (Vol. I, 36) His proposition was not in keeping with her expectations of help. However, she felt afraid that if she did not comply, he would abandon her. (Vol. I, 36) In the opinion of Dr. Perlman,

who has had experience in the treatment of sexually abused persons, the reactions she displayed were characteristic of sexual abuse. (Vol. II, 72-73)

45. The Patient's failure to initially complain of the Respondent's sexual misconduct has a logical explanation which she provided. Her exclusive concern was to raise funds and make arrangements to challenge Erin's custody in Germany. (Vol. I, 37) Her absorption is confirmed by the Respondent's testimony. *See* paragraph "42" above. Moreover, the difficulties in coming forward with a complaint of this kind are overwhelming, and would require overcoming her feelings of fear, distrust, embarrassment and self-deprecation. (Vol. I, 37; Vol. II, 68, 83) She testified that if she came forward with a complaint at the time, probably no clinician would have believed her. (Vol. I, 37)

46. Her explanation for her failure to immediately cease her contact with the Respondent is equally plausible and is intertwined with her reasons for not complaining. She was consumed in her mission to regain custody (Vol. I, 37) to the exclusion of her personal matters. The fact that she viewed the Respondent's attention "in a perverse way" as "a source of comfort" (Tr. Vol. I, 37-38) contributed to her inaction. Her transformation from ambivalence at this initial stage to antagonism toward the Respondent reflects the gradual process of recognition by the Patient. Feelings she repressed, such as anger, needed time to surface. (Vol. II, 67-68). Furthermore, she was afraid that she would not have been able to find another therapist who accepted her limited ability for pay. (Vol. II, 67) Father Cheney's observations at the time shed light on this aspect. He characterizes her as discouraged with no notion of where to turn to solve her dilemma. (Vol. II, 103)

47. In the first and successive sexual encounters, the Respondent commented that this was something they both needed, that he loved her, and that she had a beautiful body. (Vol. I, 32)

48. In each of the successive sessions with the Patient until the Patient left for Germany in November, 1979, the Patient engaged in sexual activity with the Respondent, but sexual intercourse was never consummated. (Vol. I, 34-35)

49. The sexual activity between the two was one-sided; the Patient assumed a passive role. The Respondent pursued the following: fondling, anal manipulation and attempted sexual intercourse. (Vol. I, 32, 33, 35; Vol. II, 50-51) The Patient testified that the sexual activities which she was asked to participate in, including oral and anal activity which was not performed, were "very objectionable and humiliating." (Vol. II, 49-50) The Respondent in connection with sexual activities used "street terms" to refer to her genitalia, making her feel "humiliated and degraded." (Vol. II, 49) In this regard, the Patient related to Dr. Perlman that during sexual relations the Respondent "would do something with her anus and then say something like, 'How does it feel? Isn't that good?' and 'Is so and so good?' " (Vol. II, 78)

50. The Patient's assertion that the Respondent had difficulties in consummating the relationship (Vol. I, 34-35) are believable and consistent with the evidence. The Patient testified that the Respondent explained his difficulties by stating that he was concerned about his son's problems in medical school. (Vol. II, 48-49) The Respondent's defense that he was not functionally impotent in 1979 and that he had [not had] intercourse with his wife since 1979 (Vol. II, 153) is not relevant. An inability to consummate extra-marital relations, given the stress and negative associations of such an event, is distinguishable from the capacity to function in a marital relationship. The

dent agreed that anxiety, "a fear that something is going to happen," and guilt, "a feeling about something that has happened," can cause impotence. (Vol. IV, 57-58)

51. The testimony of the Respondent's wife on the subject (Vol. III, 8, 9) can be favorably reconciled with the Patient's statements of difficulties. The Respondent's wife acknowledged that he had difficulties achieving an erection "when he was under stress." (Vol. III, 8, 9) One stressful situation affecting the Respondent, according to his wife, was the Patient's charge of sexual misconduct. (Vol. III, 14) To this extent, the testimony of the Respondent suggesting freedom from sexual problems since 1979 is incomplete. (Vol. II, 153) In any case, the existence of difficulties in one area was established and undermines the Respondent's defense. See paragraph "66" below for the finding concerning the difficulties encountered by the Respondent's son.

52. After the first sexual encounter, the Patient testified that she specifically inquired of the Respondent if their therapeutic relationship was over. The Respondent replied that he could still be her therapist. (Tr. Vol. I, 36-37, 120)

53. After the initial sexual encounter, the Patient testified that the Respondent had begun scheduling the Patient during September and October, 1979 as his last appointment when secretaries and other patients would not be around. (Vol. I, 33, 123) Exhibit 15, the appointment schedule for that period, bears out the Patient's assertion. The reasonable inference is that he was scheduling in late afternoon or early evenings to avoid the possibility of detection. The Respondent, although given the opportunity, did not provide a sufficient explanation to rebut this inference. See paragraph "114" below for discussion of this point.

54. After an initial interview, when he prepared detailed process notes, the Respondent for a subsequent session would

"jot down scribblings which [he] would refer to later when [he was] making a summary of a case" (Vol. III, 64) For the period September and October, 1979, the Respondent did not have any notes he wrote contemporaneously or immediately after his sessions with the patient.[6] (Vol. III, 64-66)

We are not persuaded that absence of process notes for the period during which sexual misconduct allegedly occurred is significant.

55. In the midst of her sexual relations with the Respondent, the Patient contacted Father Robert J. Cheney. *See* paragraph "59" below. Father Cheney, a priest of 29 years and professor at Boston College, first spoke with the Patient in connection with her induction into an Honors Society in the spring of 1977. (Vol. II, 92-93)

56. Sometime during that summer, the Patient, while on a social outing with Father Cheney, confided that she had marital problems and was in the midst of a divorce. (Vol. II, 93-94)

57. Since 1977, Father Cheney continued from time to time to speak with the Patient about some of her personal affairs and to provide advice to her. The two developed a close friendship. (Vol. II, 95, 113)

58. In connection with the custody dispute of Erin, Father Cheney prepared a supportive letter and testified as to the Patient's fitness. (Vol. II, 96)

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[6] We give little weight to the absence of process notes for the period as supportive of the allegation of sexual misconduct. The Respondent has established that her comments were repetitive and narrowly focused on her child. It is of concern that he did not document his sessions during an admittedly traumatic period for the Patient. (Vol. III, 64) Such a record could be valuable in understanding and assessing the Patient's response to this critical situation[.] (Vol. III, 64) In contrast, Dr. Perlman made detailed notes of sessions in which the Patient dealt with another major life event, i.e., her disclosure of sexual abuse. See paragraphs "106" through "110" below.

59. On September 22, 1979, as reflected in Father Cheney's journal, the Patient called him ostensibly to borrow a typewriter, but she was distraught and wanted to discuss her personal problems. This was the month of the initial sexual encounter with the Respondent. The two met to continue their conversation over lunch at the Pancake House in Brighton, which conversation Father Cheney (in his journal) characterized as "bizarre." (Vol. II, 97-99)

60. From memory, because the journal only had general references to the conversation (Vol. II, 110), Father Cheney related that the Patient began by lamenting her great misfortune in Erin's disappearance and then without warning, she just simply said that she had had a very terrible experience with her psychiatrist. Specifically, Father Cheney recounted the following:

> Well, she said she had been undergoing help, she was getting therapy. And on this particular occasion — I don't know when she was referring to, but it had been previous to our conversation, obviously.
>
> She said that she had been in the office and the doctor was very considerate, and was being very compassionate towards most of the problems that she was trying to explain. And then I got a little bit nervous because there was a language turn. She claims the doctor came over to her and began to embrace her.
>
> And then lay down on a couch or something. And he proceeded to make love to her. And I began to object; I said, "you don't really mean what you're saying," and she just continued to affirm and to describe the fact that somebody was trying to persuade her that — that this person was trying to persuade her that this would be good for her psycholog-

ically, that it would help her to relieve the tension and the pressures. And she wasn't able to resist, that she was stunned and — the elements are there. I don't recall, except that these are very strong impressions.

I just kept trying to insist that — I objected that this wouldn't be taking place by a professional person with a patient, but she just kept insisting that it had. And I said, "I have no idea what to say." I didn't know how to react. I said, "If what you're saying is true, the only thing that I can suggest is, for God's sakes, that you discontinue any association with the person." (Vol. II, 101-102)

61. The Patient did not initially disclose the name of her therapist. The name did not surface in part because of Father Cheney's reluctance to be told. (Vol. II, 104) Over the years, she repeatedly referred to the same incident of sexual abuse. In time, when Father Cheney heard the name of the Respondent, he connected the name with the original incident disclosed on that day. (Vol. II, 104-106, 116) When he received a subpoena with the Respondent's name in print, Father Cheney established in his own mind that the Respondent was the therapist the Patient had referred to. (Vol. II, 114)

62. From the circumstances related to Father Cheney, the preponderance of the evidence indicates that the person referred to by the Patient was the Respondent. Besides Father Cheney's association, the coincidence of critical factors in the two stories is overwhelmingly persuasive. There is a substantial similarity in the Patient's version of the first sexual advance and Father Cheney's version. (Vol. I, 30-32; Vol. II, 101)

As to the date of disclosure, for example, both agree it occurred in the fall of 1979 (Vol. I, 137) and this would fit

within the time frame between the first advance and this disclosure. At this time, the Respondent was the Patient's therapist. It is unrealistic to think that the Patient referred to someone else, because the Patient did not confide in Father Cheney concerning her personal relationships, including her involvement with Dr. S., but referred to the episode as arising in a professional context." (Vol. II, 113-114)

According to his own testimony, the Respondent had no reason to believe that the Patient's relationship with Dr. S. continued beyond February or March, 1979. (Vol. III, 85-86) Nor do we have reason to believe that the reference was to anyone but the Respondent.

63. The testimony of Father Cheney offers substantial corroboration of the Patient's version of events. As with the doctrine of "fresh complaint," we are impressed with the reliability of a contemporaneous complaint made to Father Cheney of events which from his testimony correspond in detail to the account the Patient now provides. His testimony together with the testimony of Dr. Perlman discussed below, is compelling evidence that the Patient's version of events is accurate.

64. The Respondent shared "a great deal about himself" with the Patient. (Vol. I, 41) The Respondent communicated to the Patient that his third wife, Delores, was living in Westport while he spent most of his week staying in Newton. (Vol. I, 41) (Vol. III, 10-14, 54-56) He also told her that one of his previous wives had died, leaving him with two children. (Tr. Vol. I, 41) (Tr. Vol. III, 54-56)

65. The Respondent does not dispute that he may have shared details with the Patient concerning his personal life: the death of his second wife leaving him with two children; his part-time living arrangements with his daughter in Newton during most of the fall, 1979; his new residence in Westport with his third wife. (Vol. III, 54-56)

66. The preponderance of the evidence shows that the Respondent spoke to the Patient about the difficulties his son encountered in medical school. (Vol. I, 41)

In 1971, the Respondent's son was in medical school. (Vol. III, 53) We do not accept Respondent's denial of statements concerning stress suffered by his son in medical school. (Vol. III, 53-54) His outright denial is difficult to accept, because the Respondent's wife related that his son had to apply three times before being admitted to medical school. She acknowledged that medical school was difficult, but she was unaware of particular stress his son was under in medical school. (Vol. III, 15-16) This does not necessarily contradict the Patient's testimony. The Patient may well have been told of difficulties which were not apparent to the Respondent's wife, since father and son primarily discussed these matters. (Vol. III, 16)

67. The Respondent's communication of details of his personal life substantiates the breakdown of the physician patient relationship and thus further corroborates the Patient's story. While we are troubled by the exclusion of evidence that the Respondent disclosed confidential patient information to the Patient (Vol. III, 78), there was other evidence to prove this matter. Obviously, the excluded evidence would have been relevant to show the intimate level of their relationship and support an inference of an inappropriate relationship. The Board Prosecutor's offer of proof demonstrates the significance of the excluded testimony. (Vol. III, 78) The confidentiality concerns could have been addressed by assigning the patient a pseudonym and impounding the testimony. Since this evidence is cumulative and the Record contains overwhelming evidence to show sexual misconduct, we need not remand this case to the Magistrate for admission of the excluded evidence. *See*, 8 Smith & Zobel, *Civil Practice*, Sec. 61 (1977) (cumulative evidence not determinative of outcome).

68. Regarding the Respondent's therapy sessions with the Patient, the Respondent conducted therapy sessions "on 2 or 3 occasions" at the Patient's residence, because she could not obtain transportation to his office. (Ex. 14) (Vol. III, 40-42) We find his later testimony limiting his home visits to one (Vol. III, 40) not convincing. His later response was given at a time when his memory was not as fresh.

We are not convinced by the Respondent's explanation for the discrepancy between his testimony and his response to interrogatories. The Respondent claimed his answer to the interrogatory referred to two or three visits outside the office, which would include visits to the hospital, as well as her residence. However, the answer itself does not make this distinction. In plain language, the answer states "[o]n 2 or 3 occasions I saw the patient at her residence in Newton . . . ." (Ex. 14) (Vol. III, 100-104)

By stating that the answer to interrogatories was prepared by his attorney, the Respondent cannot relieve himself of responsibility. He alone signed, and presumably read, the interrogatories. (Vol. III, 100) (Ex. 14)

69. On one such occasion, which the Respondent does not dispute, he conducted a 30 minute therapy session with the Patient inside his parked car. He had driven to the Patient's home at her request. (Vol. II, 157)

70. According to the Patient, the Respondent would try to make love to the Patient while in his parked car. (Vol. I, 40-41)

71. The Respondent, who averaged 10 house calls annually, saw patients at their homes if they were physically incapacitated, if they extended what the Respondent defined as a "clinical invitation," or for other reasons such as lack of transportation. The Respondent considered this a generally accepted medical practice. (Vol. III, 42-45)

72. At some point, according to the Patient, the Respondent suggested going to a motel and went with the Patient to the Golden Arrow Motel in Waltham on one occasion. (Vol. I, 34, 123)

73. It is undisputed that the Respondent dined alone with the Patient on October 16, 1979 at the University Club. (Vol. II, 154)

74. The preponderance of the evidence does not support the Respondent's version of the events leading to the undisputed fact of an October 16, 1980 dinner with the Patient at the University Club. The Respondent's version appears to be strained, at best.

The Respondent testified that on October 16, 1979, the Patient had bounded into his office at 7:00 p.m. after obtaining an order from the Essex County Probate Court granting her legal custody of her daughter and that he, the Patient, and the Patient's attorney, now Judge Catherine Izzo, had planned to go out to dinner to celebrate the legal victory. (Vol. II, 155-156; Vol. III, 68-69)

For 15 to 20 minutes before departing the Respondent's office for dinner, the Respondent claims he and the Patient discussed her custody case and court proceedings of that day. The Respondent treated this as a billable therapy session (Vol. III, 68-69) (Ex. 15) The Respondent's attempt to fit an abbreviated session into his version of events is unconvincing.

According to Judge Izzo's testimony, the Patient was not even with her on the day she obtained the custody order in question, she knew nothing of any dinner plans and thought it would have been too late to celebrate. (Vol. IV, 98-102)

75. Regardless of whether the dinner was originally planned as a group celebration for a legal victory, these plans did not materialize and the Respondent was left with the dilemma of

whether to dine alone with his patient. The Repondent, in his own words, explained his choice. ". . . so at that time, I didn't feel I could withdraw the invitation, so we went over to the University Club and had dinner." (Vol. II, 156)

76. On at least one other occasion, the Patient testified that the Respondent met with the Patient in the late afternoon and drove her to dinner at the University Club. (Vol. I, 40, 122)

77. According to the Patient, the two would exit from the Respondent's office by the back staircase to the alley. From there, they would take the Respondent's car to the University Club. At the Club, the Respondent was greeted by those who recognized him. He would hold her hand at the table. (Vol. I, 123-124)

78. On a separate occasion, the Patient stated that they walked from his office to a local cafe where they had "coffee or something." (Vol. I, 123) The two later dined in Howard Johnson's. (Vol. I, 123)

79. The Respondent had taken two other female patients to the University Club. He had also lunched at other places with patients, including the Raleigh Restaurant with "probably a dozen patients." (Vol. III, 39-40)

80. The Patient's allegation of sexual misconduct is corroborated by extrinsic evidence that the relationship between her and the Respondent had changed from a therapeutic relationship to a personal one. This is evidenced by the Respondent's admission that he took her to the University Club for dinner on at least one occasion (Tr. Vol. III, 39), the therapy session with her in his car outside of her rooming house in Newton (Tr. Vol. III, 40-45, 67-71), and by the extensive testimony of the Patient concerning contacts outside the therapeutic context.

81. Throughout their relationship, the Respondent was aware that the Patient had insufficient funds to pay him in full. At most, he collected $500.00 per year from Blue Cross/Blue Shield. (Vol. I, 38; Vol. III, 46-48) He allowed her to accumulate an average of $4,000 of medical bills. He stated that he expected that the balance would be paid when there was a divorce settlement. (Vol. I, 38; Vol. III, 46-48)

82. On one occasion, he gave the proceeds from a Blue Cross/Blue Shield check to the Patient to help her out financially. (Tr. Vol. I, 38) There was no convincing evidence to the contrary on this point.

83. The Respondent's financial arrangement with the Patient placed her in a vulnerable position in her relationship to him.

84. Sometime in mid-October, 1979, Attorney Izzo appeared before the Probate Court and had the custody order changed in the Patient's favor. (Vol. I, 149-150; Vol. IV, 100)

85. In October, 1979, the Patient informed Dr. Boyle, a psychologist, of her sexual relations with the Respondent. (Vol. I, 25, 39)

86. On or about November 1, 1979, the Patient left for Germany to obtain custody of Erin. She was joined by Attorney Izzo, who was to give testimony on the Patient's behalf. Local counsel had been retained to present her custody case in the German Courts. (Vol. I, 41-42, 135; Vol. II, 166-167; Vol. IV, 12, 60-64, 72)

87. During the period from September, 1979 to the time they left for Germany, Attorney Izzo observed that the Patient was "very upset about the child leaving" (Vol. IV, 96), but overall she tolerated the loss well. (Vol. IV, 97)

88. The Patient corresponded with the Respondent by letter dated November 2 and post marked "5/11/79." (Ex. 6) (We note the European convention of placing the numerical date before the numerical month.)

In the letter, the Patient speaks in familiar and intimate terms, referring to herself as "this sweet patient."

89. The Respondent's credibility is not necessarily undermined by his explanation for the abrupt end to the letter (Exhibit 6) without a conclusion or signature. The Respondent insisted that he had only received one page in the mail and that there was no more to the letter. (Vol. III, 90-91) While one possible inference from the evidence, is that there were additional pages to the letter, we do not choose to make this inference. The Patient's testimony is not supportive of such an inference. She does not specifically remember the letter, let alone its length or content. (Vol. II, 14-26) However, as noted above, in the first page of the letter, the Patient's tone is very casual for a normal physician-patient relationship and she specifically refers to herself as "this sweet patient."

90. The Patient returned in late January, 1980, after the German Courts rejected her claim of custody and awarded custody to her former husband and his new wife. (Vol. I, 42)

91. At the time of her return, she was "very sick," having lost weight and suffered dizziness, pain and cramping. (Vol. I, 43; Vol. III, 82)

92. She was immediately hospitalized at University Hospital with the assistance of a former Professor. She was finally diagnosed as pregnant. (Vol. I, 44; Vol. III, 83)

93. On February 4 and 6, 1980, the Respondent visited the Patient in her hospital room at University Hospital. These visits were reflected in the Respondent's billing records. (Vol.

II, 157-159) During one of these visits, the Patient told the Respondent that hospital staff were pressuring her to name the father of the child she was carrying. In her moments of disorganized and euphoric thinking, she informed the Respondent, "I told the staff if they kept asking me I was going to tell them Dr. [S.] was the father of the baby." (Vol. II, 166) There was no evidence that she actually maintained this position with the staff. (Vol. III, 87)

94. Several days later, on February 11, 1980, at 7:30 p.m., the Respondent conducted a thirty minute therapy session with the Patient inside the Respondent's car, which was parked in front of the Patient's rooming house. They discussed her plans and the problems she was presently facing. (Vol. II, 156-157) This visit was reflected in the Respondent's billing records. (Vol. II, 158-159) *See* paragraph "69" above.

95. After her discharge from University Hospital, the Patient temporarily stayed at the Howard Johnson's Motel in Newton in the hopes of continuing her pursuit of custody through the German Courts. (Vol. I, 45-46)

96. The two later dined in Howard Johnson's. (Vol. I, 123)

97. Upon her return and prior to her March, 1980 trip to Germany, the Patient and the Respondent did not resume office therapy sessions, although the Respondent did visit her at home. (Vol. I, 45) The Respondent's office records show one visit which occurred in Newton. (Ex. 15)

98. By this time, the Patient had refused to engage in sexual activity with the Respondent, because she was pregnant. The Respondent respected her wishes "to the extent that he would put his arm around [her] . . . ." (Vol. I, 45-46)

99. Upon her return from the second trip to Germany, in the late spring of 1980, she continued to see the Respondent. (Vol. I, 48)

100. Sometime in the summer of 1980, the Patient stopped seeing the Respondent. The Patient had moved to the Northampton area. There was no formal termination of the therapeutic relationship in the sense of working through and resolving outstanding issues. (Vol. I, 48; Vol. III 31-32)

101. The Patient remained in contact with the Respondent by telephone throughout the summer of 1980. (Vol. I, 25)

102. Shortly after her relocation, on August 7, 1980, the Patient, through a professional referral, began therapy with Michael Perlman, M.D. which she continued to the time of the hearing in his case. (Vol. I, 49-50; Vol. II, 59)

103. Initially, the Patient was reticent about disclosing the Respondent's conduct to her new therapist, because Dr. Perlman had informed her that the Respondent was his former supervisor. (Vol. I, 50; Vol. II, 58)

104. During the September 9, 1980 session, the Patient told Dr. Perlman that her sessions with the Respondent involved support and not intensive psychotherapy. (Vol. II, 61-62)

105. On September 22, 1980, Dr. Perlman contacted the Respondent to confirm whether the Patient was a reliable historian. She provided an "unusual" history of being a Ph.D. candidate in psychology; having had her child kidnapped by her former husband, a physician; and being presently destitute and on welfare. The Respondent verified the history and said the Patient was a "very reliable historian." As a summary of his treatment, the Respondent provided Dr. Perlman with a typed report, dated July 18, 1978, which he had prepared for Sister Millican. (Vol. II, 64; Vol. III, 22)

106. On November 4, 1980, in a session with Dr. Perlman, the Patient intimated without further explanation that the Respondent had "asked her to have a different kind of relationship than a patient/psychiatrist relationship." (Vol. II, 64-65)

107. During the January 21, 1981 session, the Patient told Dr. Perlman that she and the Respondent had had "sexual relations for a month or six weeks." (Vol. II, 65)

108. Doctor Perlman's notes of the session do not suggest that the Patient's "demeanor or affect seemed inappropriate or raised suspicions in [his] mind as to [her] truthfulness . . . ." Had this not been the case, his notes would have included such concerns. (Vol. II, 66)

109. At two sessions on October 20 and 27, 1982, the Patient revealed more of her relationship with the Respondent. On October 20, 1982, she commented that the Respondent gave her physical comfort (Tr. Vol. II, 68). One week later, she recounted the details of the relationship. As indicated in Dr. Perlman's notes, she related the following in a frightened tone:

> In the fall of 1979 I was reading a chapter of my thesis to Dr. Morris. He came over and sat on the chair beside me. He started patting me and stroking me. He said that the only thing he could give to me then was physical comfort, and asked me if I didn't want to lie down and relax. I suppose I could have walked out. Right now I'd have the strength to walk out. He wasn't charging me and Blue Cross had run out, so where could I see a therapist.
>
> He'd set up appointments to meet me late in the day and take me out to dinner at a club where the waiters knew him. His wife was living in Rhode Island, and he'd go there on the weekends. I'm only now letting myself feel how angry I am at the kind of psychiatric treatment I had. (Vol. II, 67-69, 90)

110. Subsequent to October 27, 1982, the Patient continued in therapy sessions to discuss issues surrounding her sexual

relationship with the Respondent, particularly at the time the civil case she had filed against the Respondent was coming to trial in the Superior Court. (Vol. II, 69)

111. At both the Superior Court trial and hearings before the Massachusetts Psychiatric Society, Dr. Perlman testified that he had believed the Patient's version of events. (Vol. II, 76)

112. The unqualified support of the Patient by her treating psychiatrist, Dr. Michael Perlman, corroborates the Patient's version events. On the basis of his treatment of more than ten sexually abused persons and his seventeen years of practice, Dr. Perlman was of the opinion that the emotional responses exhibited by the Patient indicated that she suffered psychic injury which is consistent with being a victim of sexual abuse. (Vol. II, 72-73, 83) In addition, he stated that he had never seen her display psychotic behavior and had never heard of anyone maintaining a fixed delusion about a sexual relationship for nine years. (Vol. II, 77)

113. Between March, 1982 and the fall of that year, the Patient communicated to a friend, Dr. Catherine Reissman, that she had been sexually assaulted by her therapist. (Tr. Vol. V, 11-12) She discussed with Dr. Reissman her concerns about suing the Respondent. (Vol. V, 13, 18-19)

Unlike the testimony of Father Cheney and Dr. Perlman, we attach minimal significance in terms of corroboration, to this communication of the sexual assault to Dr. Reissman. Father Cheney's testimony is reliable because it was contemporaneous with the events disclosed. Dr. Perlman's testimony is reliable, because he obtained his information as an independent listener in the course of therapy. The Patient's communication to Dr. Reissman was removed in time from the events and made in the context of a friendship.

114. The Respondent was not convincing in his explanation for scheduling his October and November appointments later in the day. He offererd testimony that he maintained office hours 7:00 o'clock in the morning to 8:00 o'clock in the night[.] Vol. III, 59) He may well have maintained long office hours, but this does not answer whether he changed his appointment pattern with the Patient to times when no one was in the office. The Respondent presented no documentary evidence, even though he would be expected to have had this information in his custody, concerning the appointment schedule with the Patient over the course of his treatment. He never directly addressed the issue raised by the Patient's testimony, "[s]he saw him during the day and that the appointments then became later in the afternoon and early evening. . . ." (Vol. II, 13-14) He didn't offer evidence that his October and November appointments with the Patient was in keeping with prior scheduling. If he had no change of his schedule, as the Respondent seems to contend, this would have been readily apparent from such evidence.

115. The Respondent failed to provide persuasive evidence to support his assertion that the Patient confused fact with fantasy in her disclosures of sexually related activity. (Vol. I, 106) In one instance, the Respondent testified that he believed the Patient had a certain "exhibitionistic quality" when describing her sexual activity with various people in her life, including him. (Vol. III, 37) From the Patient's recitation of her disclosures, it was apparent that she could distinguish sexual fact from fantasy. The Respondent did not provide any insight into the Patient's alleged confusion. He never analyzed the specific episodes of sexual relations disclosed during therapy sessions. Given his years of treatment, his knowledge of the patient and his qualifications, the Respondent was in the best position to highlight the examples of this behavior and discuss its mech-

anism. Support for this proposition cannot be found in the Respondent's testimony that the Patient said she would name Dr. S. as the father of the baby. The context and the manner in which the statement was made do not indicate that the Patient went so far as to accuse Dr. S. directly. (Vol. III, 86-86)

Standing alone, this and other characterizations are superficial treatments which are not developed by cogent and thoughtful analysis. In a prior proceeding before the Massachusetts Psychiatric Society concerning the same case, the Respondent offered no psychological insight into the Patient's mental status which would prompt her accusations against him. To the contrary, he testified that he was surprised by her conduct. (Vol. I, 56-57; Vol. III, 28-32) On an earlier occasion, when he could have raised the theories of causation he now asserts, his response was to say he could not have anticipated such behavior.

116. We are not persuaded by the Respondent's insinuation that the Patient's accusations were motivated by a desperate need for money. Specifically he did not support his claim that on her last visit, the Patient while looking over her shoulder, said "I don't know where I'm going to get the money. I owe over $40,000. Where am I going to get the money? I think I'll sue some of these doctors that have been taking care of me." (Vol. III, 34) His assertion is not believable for several reasons. The Patient did not make a habit of suing her treating physician. She did not sue Dr. Safon for his alleged unauthorized disclosures in breach of his duty of confidentiality. (Vol. III, 29-68-70) The Respondent had no knowledge of any lawsuits by the Patient against physicians except against him and her former husband. (Vol. III, 27) In fact, if she did make reference to suing a doctor in their conversation, it is plausible that she meant her former husband. (Vol. I, 57)

There was evidence from the Patient (Vol. I, 51; Vol. II, 28), Dr. Perlman (Vol. II, 67-71) and Dr. Riessman (Vol. V,

12-24) that the Patient's decision to pursue any legal action followed a difficult and slow course. The Patient specifically testified that she had not seen an attorney about suing the Respondent after Dr. Perlman asked her if she had consulted with an attorney. (Vol. II, 28) The Patient's delay in ultimately contacting an attorney and bringing the lawsuit against the Respondent demonstrates that she did not formulate an early intent to sue.

117. In weighing the Patient's version against the Respondent's defenses, we considered the timing of the sexual advances. It was no coincidence that the Respondent's overtures began in September, 1979. The Patient was at a very vulnerable point, and was as she testified unable to fend off his advances.

> I was as numb — I had just told the man that my child had been kidnapped, that I had been awarded by Judge Freedman a $300.00 a week court award. I had no money. I didn't know where my child was. My issue for Dr. Morris was to help me determine what I should do. When his response was that I should have physical sexual activity with him I was completely left astounded, bewildered. And I was afraid, I think, unconsciously, that if I didn't comply with his request that he would abandon me. (Vol. I, 36)

The Patient's version is enhanced by the fact that the Respondent took advantage of an opportune time to make his advances.

118. We adopt paragraph 15 of the Findings of Fact in the Recommended Decision, and supplement the finding with additional findings and transcript references. The Patient filed

an action against the Respondent in the Hampshire County Superior Court. (Docket No. 82-1694) This case was settled before completion of the trial, and the action was dismissed with prejudice (see Ex. 4). As a term of the settlement, the Patient promised not to pursue further any outstanding complaints she had against the Respondent with the Board of Registration in Medicine, the Massachusetts Psychiatric Society and the Massachusetts Medical Society. (Vol. I, 54) (Exhibits 4 and 5) She testified before the Magistrate under subpoena.

119. The respondent settled the civil suit for $90,000; we do not rely upon this fact in our findings.

The agreement signed by the Patient not to pursue further actions, which was a part of the settlement, will also not be considered.

We do not fault the Magistrate for refusal to permit inquiry as to whether any of the money paid to the Patient as part of the civil settlement was the Respondent's own personal money. (Vol. III, 92-93)

120. There was no error in excluding testimony that the Patient was intimidated prior to providing testimony. (Vol. III, 96-97) Such testimony is not relevant, since the Patient testified at the hearing without any apparent chilling effect on her testimony.

IV. CONCLUSIONS OF LAW

A. The Board is charged with the duty to determine when a physician's actions[7] in the course of his medical practice depart from good and accepted medical practice constituting

[7] The Supreme Judicial Court of Massachusetts has held that the relevant actions include "all conduct of the practitioner in carrying out his professional activities" and are not limited to the diagnosis and treatment of the patient. *Forziati* v. *Board of Registration in Medicine*, 333 Mass. 125 (1955).

"gross misconduct in the practice of medicine" within the meaning of G.L. c. 112, secs. 5(c) and 61 and 243 CRM 1.03(5)(a)(3). *Ryan* v. *Board of Registration in Medicine*, No. 82-1 (Supreme Judicial Court, August 13, 1982) (Memorandum of Decision) (citing *Levy* v. *Board of Registration and Discipline in Medicine*, 378 Mass. 519, 524-525 (1979)), *aff'd*, 388 Mass. 1013 (1983) (Rescript); *In the Matter of Leonard Friedman, M.D.*, No. 86-1-BO (Board of Registration in Medicine, June 24, 1987) (Final Decision and Order)

B. There is no requirement that the Board adopt the Hearing Officer's Recommended Decision as its own decision. *Sullivan* v. *Municipal Court of the Roxbury District*, 322 Mass. 566 (1948); *Haywood* v. *Municipal Court of the City of Boston*, 359 Mass. 760 (1971); *Commissioner of Revenue* v. *Lawrence*, 379 Mass. 205 (1979); *Vinal* v. *Contributory Retirement Appeal Board*, 13 Mass. App. Ct. 85 (1982). *See, also*, Opinion of the Attorney General, No. 17, January 12, 1978, pp. 112-113.

C. As the ultimate decision maker in an adjudicatory proceeding, the Board "is not bound by the ultimate conclusions of the hearing officer or examiner, but is free to rest its own decision upon his subsidiary findings." Cella, *Administrative Law and Practice*, sec. 350, at 657 (1986)

D. Where there is a departure from the Recommended Decision, M.G.L. c. 30A, sec. 11(b) requires that reasons for disagreement be articulated. *Vinal, supra.*

E. While the Hearing Officer's firsthand observations cannot be easily ignored, *Vinal*, 13 Mass. App. Ct. at 85, her findings should not be "given more weight than in reason and in the light of judicial experience they deserve." *Universal Camera Corp.* v. *National Labor Relations Board*, 340 U.S. 474, 469 (1951).

F. The determination of whether to believe the testimony of one witness instead of another involves more than observation of demeanor and appearance. A credibility determination entails "the over-all evaluation of testimony in light of its rationality or internal consistency and the manner in which it hangs together with other evidence." *Carbo* v. *United States*, 314 F.2d 718, 749 (9th Cir. 1963); *Penasquitos Village, Inc.* v. *N.L.R.B.*, 565 F.2d 1074, 1086 (1977) (Dunway, J. Dissent). On this Record, it is abundantly clear that the Magistrate did not discuss the testimony in light of its rationality or internal consistency and she certainly did not discuss the relationships among the Patient's and the Respondent's testimony and the other evidence.

G. A Hearing Officer listening to testimony is in no better position than the Board to reach conclusions concerning the consistency and inherent probability of testimony. Moreover, the conclusions of the Board in this area are controlling, even if the Hearing Officer formed another equally reasonable conclusion. *Adolph Coors Co.* v. *F.T.C.*, 497 F.2d 1178, 1184 (10th Cir. 1974) ("Coors").

H. "Although the Board may not overrule an examiner by ignoring credible evidence of a witness and drawing inferences from tenuous circumstances, it is not compelled to follow the examiner or his findings conflicting with well supported inferences drawn from other parts of the record." *Russell-Newman Manufacturing Co.* v. *N.L.R.B.*, 407 F.2d 247 (Cir. 1969); *N.L.R.B.* v. *Treasure Lake, Inc.*, 453 F.2d 202 (3rd Cir. 1971).

I. Even after considering the deference to be accorded the Magistrate's finding concerning demeanor, we find that her ultimate finding of no sexual misconduct cannot stand. As noted throughout, the Magistrate simply provides scant, if any, insight into her decisionmaking process. We are given no clues

as to what she relied upon in making her subsidiary and ultimate findings.

The Magistrate based her ultimate finding "*in part* on my finding that the testimony of the Respondent was more credible than [the Patient's] testimony." In making this finding, the Magistrate failed to give even the most minimal explanation as to what it was about the witness's "appearance and general bearing" which influenced her credibility determination.

The failure to provide a minimal articulation as to her analysis of credibility is all the more troubling, in light of the Recommended Decision's complete lack of analysis of any of the corroborating evidence presented by the Associate Prosecutor: Father Cheney's corroborating testimony, the Respondent's house calls, the change in scheduling, the therapy session in the car, the letter referring to "this sweet patient," the Respondent's dining alone with his patient, the personal financial dealings, the testimony of Dr. Perlman, and the testimony of Catherine Riessman.

In rejecting the Magistrate's Recommended Decision on this issue, we conclude that it is deficient and fails to consider the evidence as a whole. According to the Recommended Decision, the Patient could not be believed, because her testimony was "uncorroborated and unsubstantiated." (Recommended Decision, p. 9) The Magistrate focused on the absence of any third party eyewitness to the therapy sessions or to interaction between the Patient and the Respondent. (Recommended Decision, p. 8) In this context, we do not accept the Magistrate's *automatic* connection between the absence of additional eyewitnesses and the credibility of the Patient's testimony. Since therapy sessions are by their very nature confidential, no third party witness would ever be present. Nor would it rationally be expected that there would be witnesses to any of the events in view of the resulting threat to the Respondent's marriage and his professional standing. We do not think the

courts would require a directed verdict for the psychiatrist every time a patient, claiming sexual misconduct, failed to produce a third party eyewitness.

Notably absent from the Magistrate's assessment of the Patient's story are any findings concerning bias, prejudice, prior inconsistent statements or analysis showing her story was inherently improbable.

The Magistrate said her decision was based "in part" on credibility, and did not state what factors or reasons she relied upon beyond this basis. Unarticulated grounds for a decision provide no guarantee to the Board that a Hearing Officer's recommended decision is not arbitrary.

In contrast to the Magistrate's credibility determination, our findings concerning credibility, corroboration and all of the other supporting evidence, are clearly articulated and rationally support our ultimate findings of sexual misconduct. We decline to accept blindly the Magistrate's insubstantial and sparse credibility finding since it presents conflicts with well supported inferences drawn from other parts of the record and our findings, which conflicts the Magistrate never addressed. Given the overwhelming evidence of sexual misconduct, this case can be decided without remanding the matter to the Magistrate.

J. "The weighing of evidence to reach a conclusion as to its preponderance is a judgment within the Board's specialized expertise, and one which, if based on substantial evidence and not otherwise clearly "erroneous" should be sustained. *Kobrosky* v. *Board of Registration and Discipline in Medicine*, No. 70-239 Slip op. at 6 S.J.C. August 14, 1980) (Memorandum of Decision); *Arthurs* v. *Board of Registration in Medicine*, 383 Mass. 299 (1981).

K. In this case, the Board has applied its expertise in the fact-finding process and has drawn reasonable inferences from the facts found. The Board has an expertise which the Magis-

trate does not have. In applying its expertise, the Board has been careful not to use its special training to substitute for evidence not contained in the Record. There is undisputed evidence on the issue of sexual relations. The parties and the testimony uniformly condemn sexual relations between a psychiatrist and his patient. An overview of the subject of sexual exploitation, particularly of the dynamics of the psychiatrist-patient relationship in this context, is essential background for any analysis of cases of sexual misconduct by psychiatrist. Moreover, through our work in the field and handling of disciplinary cases, we have gained an understanding of how to interpret and weigh the particular facts in a case of sexual abuse. It is through this insight and expertise in reviewing such cases that we can identify certain red flags indicative of sexual abuse. Without this appreciation, critical facts can be misinterpreted or worse yet, ignored.

Various forces are at play in the psychiatric setting which facilitate sexual contact and hamper disciplinary intervention. The relationship of therapist-patient is unique to the medical profession. By virtue of the intensity of the therapeutic relationship, a psychiatrist's sexual and other needs and fantasies may be activated with the resulting loss of objectivity necessary for control. See Conclusions of Law letter "M." The special quality of the relationship also can afford an offending psychiatrist with the opportunity to initially take advantage of his patient and later avoid detection. He gains intimate details concerning his patient, details so personal that the patient might never have previously revealed them. It is this access to a patient's thoughts and behavior which distinguish the psychiatrist from other medical professionals, and it is this access which can be exploited. A therapist can learn the sexual history, the proclivities and the vulnerabilities of his patients. With this information, he may discover which patients are susceptible to his overtures. *See, e.g., In the Matter of Rodolph Turcotte, M.D.,*

Case No. 85-21-DE Slip. op. at 31 (Board of Registration in Medicine, November 19, 1986) (Final Decision and Order) (psychiatrist exploited special knowledge to obtain loans from patient)[.] The last refuge for an emotionally traumatized and vulnerable patient is often the psychiatrist. *See, Dresser* v. *Board of Medical Quality Assurance*, 130 Cal.App.3d 506, 181 Cal. Rptr. 797, 799-800 (1982); *Berstein* v. *Board of Medical Examiners*, 204 Cal.App.3d 378, 381, 22 Cal. Rptr. 419 (1962). The patient's faith in the therapist, a faith built on trust and confidence, is turned against the patient in this situation.

Given the outright prohibitions and stigma associated with sexual conduct with a patient, an offending psychiatrist has good reason to avoid detection. The threat that a psychiatrist might misuse or disclose confidential information gained in therapy can act to silence a patient complaint. Regrettably, the Patient in this case was made to pay a high price in this respect.

The inequities inherent in this relationship raise other considerations. In relation to his patient, a psychiatrist stands as a strong authority figure, who has tremendous influence and sway over his patient. While it is natural and anticipated that the therapist will exercise his influence to provide insight and give guidance, his influence can be directed to less noble purposes. In some cases, little is necessary to bend a patient, who is eagerly seeking approval, to a psychiatrist's will. Paragraph 3 of Section 1 of the American Psychiatric Association, *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (1978 ed.) (hereinafter referred to as "*Principles*") recognizes the ever-present danger of exploitation and directs psychiatrists to diligently guard against abuses

of their power. *See* Conclusion of Law "M" for discussion of Board's reliance on the "Principles."[8]

The psychiatrist is presented with other opportunities to exploit his position of trust, confidence and power to obtain sexual favors. *See, e.g., In the Matter of Leonard Friedman, M.D.*, Case No. 86-1-BO (Board of Registration in Medicine, June 24, 1987) (Final Decision and Order) (Patient dependent on reports from psychiatrist to keep her disability benefits); *In the Matter of Ponciano De La Cruz, M.D.*, No. 926 (Board of Registration in Medicine, Dec. 10, 1986) (physician used his authority to prescribe to obtain sexual gratification)

L. The professional relationship is compromised when a psychiatrist fails to confine himself/herself to a professional role and fails to maintain a professional objectivity and distance from his/her patients. The physician should take all steps to avoid crossing the boundaries separating reasonable professional conduct and unacceptable personal relations. *In the Matter of Leonard Friedman, M.D.*, Case No. 86-1-BO (Board of Registration in Medicine, June 24, 1987) (Final Decision and Order); *In the Matter of Harold J. Kosasky, M.D.*, Case No. 10071 (Board of Registration in Medicine, March 4, 1987) (Final Decision and Order);

The professional relationship between the Respondent and the Patient was compromised as evidenced by:

1. The shift to an intimate level through the Respondent's sharing of the details of his personal life with the Patient;

2. The financial arrangements between the Respondent and the Patient. The Respondent expected payment in full from the divorce and yet permitted the Patient to continue in treatment and run up an arrearage even when it became reasonably

[8] As we stated in *Turcotte*, we rely upon the edition contemporaneous with the events in question, and the Board expects all psychiatrists to adhere, at a minimum, to such current standards.

apparent after the divorce that he would not collect the remainder.[9] Moreover, the Respondent turned over an insurance payment to the Patient.

3. The extracurricular social activity between the Respondent and the patient of the opposite sex, specifically dining alone with the patient.[10]

4. The Respondent's conduct of psychiatric sessions in inappropriate settings such as his car.[11]

M. The minimum standards of practice and ethical behavior in this case are established by the testimony of the Respondent

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[9] In permitting Patient to continue in his care, when she could no longer pay for services, and run up an arrearage for services rendered, the Respondent did not claim he was providing free care. By itself, the provision of free care is a laudable objective, no matter what the reasons, which we do not wish to deter. Under these circumstances, it takes on a different hue. Under no circumstances, however, can we justify Respondent's conduct in turning insurance payments over to the Patient.

[10] This is an improper interaction, because it destroys the professional barrier between the psychiatrist and patient and weakens the objectivity and control necessary to avoid sexual encounters. The Respondent's dinner engagement alone with the Patient represents the kind of deviation which is of concern to the Board. Given our findings on the matter, we are unable to give the circumstances surrounding this arrangement any interpretation which would render these meetings appropriate. Because it may be acceptable, and in some cases a business necessity, for an attorney to casually socialize with his clients, lawyers (such as the Magistrate) may overlook the impact of such an encounter in this setting. To allow such interaction in the field of psychiatry can compromise the practice and the efficacy of therapy.

[11] However praiseworthy from the standpoint of convenience to the patient, therapy sessions should not be conducted in improper settings. The therapy sessions in the Respondent's car transforms the tenor of the relationship from profefssional to personal. Generally, sessions conducted in a patient's home, without a more compelling necessity than unavailability of transportation, are inappropriate. Whether the literature supports home visits as a general proposition, (Vol. III, 103-104), the need in this case does not outweigh the risk of harm. This case does not present the necessity of the case involving a physically disabled person. (Vol. III, 42-45) In this circumstance, the professional relationship was jeopardized. With such a shift in character, there is a real threat to professional objectivity and control. For that matter, even the courtesy of driving a patient home after a session may well be detrimental to the delicate balance of the professional relationship.

and Dr. Perlman and are entirely consistent with those in the *Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry* (published by the American Psychiatric Association), previously cited in the *Friedman* and *Turcotte* decisions.

In relevant part, the 1978 edition of the *Principles* states:

> The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.
>
> 1. The Patient may place his/her trust in his/her psychiatrist knowing that the psychiatrist's ethics and responsibilities preclude him/her from gratifying his/her own needs by exploiting the patient. This becomes particularly important because of the essentially private, highly personal, and sometimes intensely emotional nature of the relationship established with the psychiatrist.
>
> 2. The requirement that the physician "conduct himself with propriety in his profession and in all the actions of his life" is especially important in the case of the psychiatrist because the patient tends to model his/her behavior after that of his/her therapist by identification. Further, the necessary intensity of the therapeutic relationship may tend to activate sexual and other needs and fantasies on the part of both patient and therapist, while weakening the objectivity necessary for control. *Sexual activity with a patient is unethical.*

N. The Respondent engaged in inappropriate sexual and other activity with the Patient, in violation of good and accepted psychiatric care.

O. The Respondent by his inappropriate sexual and other activity with the Patient has committed gross misconduct in the practice of medicine, in violation of G.L. c. 112, section 5(c) and 243 CMR 1.03(5)(a)(3).

V. Sanction and Order

The Respondent's offenses involve various gradations in the spectrum of gross misconduct. Dining with a patient alone and conducting therapy sessions in improper settings represent one level of offenses. Because they tend to undermine the relationship, they would merit a disciplinary response and a possible sanction of suspension. *In the Matter of Harold Kosasky, M.D.*, Case No. 10071 (Board of Registration in Medicine, March 4, 1987) (Final Decision and Order).

Sexual exploitation of a patient is a separate and more egregious offense. It involves the complete breakdown of the relationship, exposing its victim to serious and potentially irreparable harm. To reiterate, we strongly condemn this conduct.

Consistent with treatment accorded other similar cases of sexual exploitation, *In the Matter of Leonard Friedman, M.D.*, Case No. 86-1-BO (Board of Registration in Medicine, June 24, 1987) (Final Decision and Order), the Respondent's registration to practice medicine in the Commonwealth of Massachusetts is hereby REVOKED.

This sanction is imposed for the violation set forth in either Conclusions of Law "N" or "O," and not on the basis of both. The Respondent has the right to appeal this Final Decision and Order within 30 days, pursuant to G.L. ch. 30A, secs. 14 & 15, and G.L. 112, sec. 64. The Respondent is directed

to surrender his original certificate and any unexpired wallet card within fourteen (14) days' receipt of this Final Decision and Order.

Date: _____ /s/ _____
Andrew G. Bodnar, M.D., J.D.

Appendix H.

[Doctor's Complaint in the Massachusetts Supreme Judicial Court.]

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS. SUPREME JUDICIAL COURT

THOMAS A. MORRIS, JR., M.D., Plaintiff,	)	
v.	)	NO. 88-81-CIV.
MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE, Defendant.	)	VERIFIED COMPLAINT

INTRODUCTORY STATEMENT.

1. (a) In accordance with G.L. c. 112, § 64, and G.L. c. 30A, § 14, the plaintiff physician, duly licensed and practicing under the laws of the Commonwealth, appeals from a Final Decision and Order of the Massachusetts Board of Registration in Medicine dated February 3, 1988, and purporting to revoke his registration to practice medicine.

(b) The Board's Final Decision is extraordinary. It rests upon a finding that the physician, on six occasions of office visits, initiated sexual relations with a patient. It is undisputed that doctor and patient were alone during all of the alleged encounters. The Board referred the charge to the Divison of Administrative Law Appeals for an adjudicatory hearing. An

experienced Administrative Magistrate conducted five days of hearings. At their conclusion she found, upon the basis of the demeanor and credibility of the two principals, that the doctor's testimony was "compelling" and the patient's "not convincing." She found in favor of the physician and recommended the dismissal of the charges.

(c) Without further hearing or evidence and after an interval of more than one year and four months, the Board rejected the Magistrate's finding and substituted its own finding that the physician had committed the conduct charged. It based its findings upon (1) putative errors in the perception and mental processes of the Magistrate; (2) inferences to be drawn from circumstantial evidence; and (3) a purported "expertise which the Magistrate does not have" upon the subject of credibility in cases of sexual abuse.

Detailed allegations follow.

PARTIES.

2. The plaintiff Thomas A. Morris, Jr., is a practitioner board-certified in psychiatry and neurology. He graduated from the University of Pennsylvania Medical School in 1941; served in the Medical Corps of the Navy from 1942 to 1947; thereafter became a psychiatric resident at the Cushing Hospital in Framingham, Massachusetts; served on the staff of the Peter Bent Brigham Hospital and Massachusetts Mental Health Center from 1955 through 1972; and since 1973 has been engaged in the private practice of psychoanalysis and psychotherapy. He presently maintains offices at 82 Marlborough Street, Boston; and at 48 North Street, New Bedford.

3. Doctor Morris was born in 1916. At the time of the alleged misconduct (September and October, 1979), he was 63 years of age.

4. The defendant Board of Registration in Medicine, pursuant to G.L. c. 112, §§ 2-12R and 243 CMR 1.00 through 2.08, regulates the licensure in, and practice of, medicine within the Commonwealth.

JURISDICTION.

5. The court derives jurisdiction of the present action from G.L. c. 112, § 64; G.L. c. 214, § 1; and its inherent authority at common law and in equity.

FACTUAL ALLEGATIONS.

6. On April 17, 1985, the Board of Registration (the Board) issued against Dr. Morris an Order to Show Cause alleging:

(a) gross misconduct in the practice of medicine in violation of G.L. c. 112, § 5(c), and 243 CMR 1.03 (5)(a)(3); and

(b) violation of a rule or regulation of the Board governing the practice of medicine in contravention of G.L. c. 112, § 5(h) and 243 CMR 1.03(5)(a)11.

7. The alleged misconduct underlying both charges was that "[f]rom September, 1979 to November, 1979, the Respondent during scheduled therapy sessions at his office, initiated sexual relations with [the patient Kathleen] Martin at least six times."

8. By formal Answer, Dr. Morris denied all charges.

9. The Board referred the case to the Division of Administrative Law Appeals for findings of fact and a recommended decision. G.L. c. 7, § 4H. Administrative Magistrate Joan Friedman Fink conducted an adjudicatory hearing of five ses-

sions on May 28, June 17, July 1, July 14, and July 21, 1986. On September 18, 1986, she rendered her findings and Recommended Decision, a copy of which appears as Exhibit A to the present Complaint. On or about February 5, 1988, the Board rendered its Final Decision and Order, a copy of which appears as Exhibit B to the present Complaint. The Board's mailing of the Decision never reached Dr. Morris' then counsel of record. That attorney learned of the Decision from third parties and retrieved a copy on or about February 26.

10. It is undisputed that Kathleen Martin had been a patient for therapy since May, 1977; and that she remained a patient of Dr. Morris until June, 1980. She saw the doctor approximately once a week for the period of June, 1977 through November, 1979; and on occasion thereafter from January 29, 1980, through July 15, 1980.

11. Ms. Martin had received a bachelor of arts degree from DePaul University; a masters degree in educational psychology from the University of Minnesota; and by late 1979 had completed work for her doctoral degree in counseling from Boston College. At the time of the Magistrate's five hearings in 1986, Ms. Martin was a licensed psychologist practicing at the University of Massachusetts in Amherst and at Amherst College.

12. At the beginning of her treatment in May, 1977, upon the basis of interviews and medical records concerning hospitalization and lithium treatment for manic depressive illness, Dr. Morris formulated a working diagnosis that Ms. Martin suffered from a non-psychotic affective disorder (cyclothalmic illness) characterized by mood swings and evidenced by the formation of inappropriate relationships, high-risk ventures, volubility, racing thoughts, and insomnia.

13. In addition to therapy sessions the patient received a variety of medication, including valium, dalmane, and nardil

over the course of her treatment. She had experienced undesirable side effects from previous trials on lithium, and refused to take it from Dr. Morris.

14. Ms. Martin sought therapy as the result of marital and child custody problems.

(a) Ms. Martin had been married from 1968 until February, 1979 (the time of finalization of her divorce) to Bernard Glvechlich, a physician from Cologne, West Germany. In June, 1977, she had separated from her husband.

(b) The couple had one child, a daughter born in 1972.

(c) In the spring of 1976 Ms. Martin had undergone an abortion in California. In consequence, in May of that year, she was hospitalized as a psychiatric inpatient for two weeks at the Tufts New England Medical Center.

(d) In April of 1977 she was again hospitalized as a psychiatric inpatient, this time at the Salem Hospital and Glenside Hospital for a total of three weeks.

(e) In early September, 1979, Ms. Martin's ex-husband returned to Germany and took with him their daughter.

(f) During September and October — the period of the alleged misconduct by Dr. Morris — the patient was distraught and engaged in preparations to raise money, to travel to Germany, and to regain custody of her daughter in the German courts.

15. Ms. Martin did travel to Germany in November, 1979, but lost her custody effort in the German courts.

16. En route back to the United States she spent several weeks in England and became pregnant by a friend in that country.

17. She returned to Massachusetts in January, 1980, and continued therapy sessions with Dr. Morris until June of that year.

18. The foregoing facts appear as undisputed findings of the Magistrate and/or the Board. The findings and Recommended Decision of the Magistrate appear as Exhibit A to the present Complaint. The Final Decision and Order of the Board appears as Exhibit B.

19. The Magistrate concluded her findings as follows:

> During the five days of hearing, I had ample opportunity to observe the demeanor of the witnesses including their appearance and general bearing. In addition I had an opportunity to consider the general tenor of their testimony . . . .
>
> I find the Respondent (Dr. Morris) to be a compelling and credible witness and further find that his testimony denying the allegations of sexual impropriety was more likely than not to be true. Conversely while I sympathize with Dr. Martin concerning her difficult domestic problems, nonetheless I find that her uncorroborated and unsubstantiated testimony related to her repeated sexual encounters with the Respondent was not convincing.

20. The Board, which never observed either principal, concluded that the patient was telling the truth and the doctor lying,

(a) because circumstantial evidence permitted the inference of an unprofessional relationship (the doctor on one occasion dined alone with the patient after a session; once made a house call to her residential quarters when she lacked transportation; and permitted her to accumulate a fee arrearage while she lacked funds);

(b) because the Magistrate must have prejudicially permitted the patient's troubled mental, sexual, and marital history to divert her (the Magistrate's) attention from the doctor's alleged behavior to the complainant's conduct (even though the Magistrate's finding rests directly on first-hand observation of demeanor over five hearings and even though the Magistrate would have been fully entitled to consider evidence affecting the complainant's capacity for observation and recollection of material events and her subsequent credibility; and

(c) because the Board possesses special expertise in the detection of sexual offenses, in the form of its awareness from literature that the psychiatrist-patient relationshipo is more susceptible of sexual exploitation than the usual physician-patient relationship.

22. The Decision and Order of the Board immediately revokes the doctor's registration to practice.

23. Doctor Morris presently maintains an active practice of 102 patients in two offices in Boston and New Bedford.

24. He averages approximately 50 appointments per week.

25. Approximately 15 to 20 percent of his patients suffer from severe mental disorders and require ongoing attention.

26. A substantial portion of his practice consists of Medicaid patients who would prove difficult to transfer to other psychiatrists.

27. A substantial segment of his patients consists of workmen's compensation claimant patients who would prove difficult to transfer to other psychiatrists.

28. Doctor Morris' appointment schedule is presently booked for approximately four weeks in advance, or to the end of March, 1988.

CAUSES OF ACTION.

29. COUNT ONE. *Violation of Due Process Guaranteed by the Massachusetts Constitution.* The Decision and Order of the Board constitute a denial of procedural due process guaranteed by Articles 1, 10, 12 and 29 of the Declaration of Rights of the Massachusetts Constitution. G.L. c. 30A, § 14(7)(a).

30. COUNT TWO. *Violation of Due Process Guaranteed by the United States Constitution.* The Decision and Order of the Board constitute a denial of procedural due procerss guaranteed by the Fourteenth Amendment of the United States Constitution. G.L. c. 30A, § 14(7)(a).

31. COUNT THREE. *Unlawful Procedure.* The Decision and Order of the Board are based upon unlawful procedure within the meaning of G.L. c. 30A, § 14(7)(d).

32. COUNT FOUR. *Lack of Substantial Evidence.* The Decision and Order of the Board are unsupported by substantial evidence within the meaning of G.L. c. 30A, § 14(7)(e).

33. COUNT FIVE. *Agency Decisionmaking Arbitrary, Capricious and Abusive of Discretion.* The Decision and Order of the Board are arbitrary, capricious, and abusive of discretion within the meaning of G.L. c. 30A, § 14(7)(g).

34. COUNT SIX. *Error of Law.* The Decision and Order of the Board constitute an error of law within the meaning of G.L. c. 30A, § 14(7)(c), by reason, inter *alia*, of their bias, prejudice, and prejudgment.

RELIEF.

WHEREFORE, the plaintiff prays:

1. that, pursuant to Mass. R. Civ. P. 65(a), the court enter an order temporarily restraining the revocation of the Massachusetts registration of the plaintiff Thomas Morris, M.D.;

2. that the court issue a short order of notice of hearing upon the request in prayer 3 for preliminary injunctive relief against the revocation of the plaintiff's Massachusetts registration, returnable at the regularly scheduled session of the single justice at 9:30 A.M., Wednesday, March 9, 1988;

3. that, pursuant to Mass. R. Civ. P. 65(b), the court enter an order preliminarily enjoining the Massachusetts Board of Registration in Medicine from the revocation of the registration of Thomas Morris, M.D., until the final adjudication of the merits of the present action;

4. that the court order speedy completion of the pleadings, preparation of the record, and the submission of written briefs and oral argument upon the merits within 90 days of the entry of preliminary injunctive relief;

5. that, upon final adjudication, the court enter judgment annulling and setting aside the Decision and Order of the Board of Registration purporting to revoke the registration of Thomas Morris, M.D.; and

6. that the court grant such other relief as it deems just, equitable, or appropriate in the circumstances.

By his attorney,

/s/ _____

VERIFICATION.

The undersigned plaintiff has read the foregoing complaint and affirms that its allegations are true and accurate as a matter of personal knowledge or as a matter of information and belief.

/s/ _____
Thomas A. Morris, Jr., M.D.

Dated:

Subscribed and sworn to before me this _____ day of March, 1988.

_____
Notary Public

My commission expires:

_____

Appendix I.

[Decision of the Single Justice of the Massachusetts Supreme Judicial Court.]

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, SS. SUPREME JUDICIAL COURT
NO. 88-81 CIV.

THOMAS A. MORRIS, JR.

v.

BOARD OF REGISTRATION IN MEDICINE

MEMORANDUM AND ORDER

The plaintiff seeks review of a decision of the Board of Registration in Medicine, dated February 3, 1988, revoking his license to practice medicine for engaging in sexual misconduct with a patient.

An administrative magistrate of the Division of Administrative Law Appeals conducted five days of hearings during which she heard testimony of both the complainant and the plaintiff. In her recommended decision she resolved the credibility issues in favor of the plaintiff and found that the complainant's testimony concerning sexual encounters with the plaintiff was unconvincing. Since sexual impropriety was the only basis of the complaint the magistrate recommended that the charges be dismissed.

The Board did not accept the magistrate's recommendation and on a review of documentary evidence, without further hear-

ings or live testimony, rejected the finding of the magistrate and found that instances of sexual activity had occurred between the plaintiff and the complainant.

In substance, this case is a duel of credibility. The board believes the complainant and the magistrate believes the plaintiff. The decision of the Board must be based upon substantial evidence, a standard which requires the reviewing court to consider the entire record, taking into account whatever in the record detracts from the weight of the agency's opinion. *Arthurs* v. *Board of Registration of Medicine*, 383 Mass. 299 (1981).

Therefore, the circumstantial and other evidence admitted for the purpose of corroboration must be evaluated in the context of the magistrate's credibility determinations. "[E]vidence supporting a conclusion may be less substantial when an impartial, experienced examiner who has observed the witnesses and lived with the case has drawn conclusions different from the Board's than when he has reached the same conclusion . . . The significance of his report, of course, depends largely on the importance of credibility in the particular case." *Universal Camera Corp.* v. *NLRB*, 340 U.S. 474, 496 (1951). Here, credibility determinations were central and hearsay corroboration is without probative effect if the complainant's testimony is disbelieved.

The Board could have heard the witnesses itself or remanded the case to the magistrate for further hearings if it concluded that the magistrate's findings were inconsistent, insufficient, or lacking in evidentiary support. On the record before it, however, it did not have substantial evidence that the instances of sexual misconduct complained of occurred.

ORDER

For the reasons stated the order of the Board of Registration in Medicine suspending the petitioner's license to practice medicine is hereby vacated.

/s/ _____

Dated: April 4, 1988 Associate Justice

A true copy.
Attest:

April 4, 1988 Clerk

Appendix J.

[Board's Publication of Sanction Against Doctor.]

Commonwealth of Massachusetts
Board of Registration in Medicine
Ten West Street
Boston, Massachusetts 02111
(617) 727-3086

RALPH A. DETERLING, JR., M.D.
CHAIRMAN

BARBARA NEUMAN
EXECUTIVE DIRECTOR

An Agency within the Executive Office
of Consumer Affairs and Business Regulation

DATE: February 11, 1988

TO:
American Medical Association
Blue Cross/Blue Shield Law Dept.
Boston Globe – Richard Knox, Judy Foreman, Richard Saltus
John Hancock Preferred Health Plan
Lowell District Attorney's Office
Mass. Board of Pharmacy
Mass. Dept. Welfare Provider Review & Sanctions Unit
Mass. Hospital Association
Mass. Psychiatric Society

NYNEX–Legal Department

Alternative Delivery Systems
Springfield Daily News
Daily Hampshire Gazette
Worcester Telegram

Blue Shield of Massachusetts Division of Registration
Federal Drug Enforcement Administration
Joint Underwriting Association
Managed Health Care Service, Inc.
Mass. Controlled Substances
Mass. Dept. Public Health – Division of Food & Drugs
Mass. Medical Society
Mass. State Police – Diversion Investigative Unit
State House Press Gallery
Mass. Assoc. Medical Staff Services
American Osteopathic Association
Consumer Affairs – Merry Duffy
Lynn Item

RE:	DISCIPLINARY ACTION
NAME:	Thomas A. Morris, Jr., M.D.
ADDRESS:	51 Libby Street Brockton, Massachusetts 02401
CERTIFICATE NUMBER:	22168
REASON:	Sexual Misconduct
TYPE OF ACTION:	Revocation
DATE OF ACTION:	February 3, 1988

/s/ _____
Andrew G. Bodnar, M.D., J.D.
Chairman